

Modern Life Insurance

A TEXTBOOK OF INCOME INSURANCE

MODERN

Third Edition

LIFE INSURANCE

A Textbook of Income Insurance

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NEW YORK THE MACMILLAN COMPANY

This edition is dedicated
to my wife, Margaret, and son, Laurie,
for whom the royalty checks will
make more interesting and exciting reading
than the text.

—R.I.M.

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First Printing

Library of Congress catalog card number:
61-6420

The Macmillan Company, New York
Brett-Macmillan Ltd., Galt, Ontario

Printed in the United States of America

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Preface

This edition of *Modern Life Insurance* is a thoroughgoing rewrite of the Revised Edition, which was an almost 100 per cent rewrite of the first edition . . . and that's the trouble with Mehr and Osler. They cannot revise. They can only rewrite. Since it is a demonstrable fact that both authors can earn more money for their time doing things other than writing a college text for an elective course, their fault is an annoyance to them. It is also the nightmare of their publisher, who points out that he, too, can make more money on things other than throwing away the plates of a current edition and resetting an entire book.

In the "Preface" of the Revised Edition, the authors used as their excuse for what was almost a 100 per cent rewrite, the fact that the business had undergone many changes since the first edition. This time they are not deluding themselves. This over-65 per cent rewrite is simply a result of the fact that they are incapable of letting good enough alone. They are always smitten with the idea that they can "do it a little better this time."

Call it a compulsive psychosis, and let it go at that.

Actually, the greatest change in this edition is that it is not a 50-50 co-authorship, as in the past two editions, but more like a two-thirds-one-third authorship. This change came about as a result of the fact that during the same period over which the revision had to be made, R. W. Osler was involved in a business matter requiring exceptional attention. His work in the actual revision of the copy was probably no more than 20 per cent, the other 13 per cent being made up by handling such details as editing, proof, index, and the like. In other words, at least 80 per cent of the rewritten portions of the edition are to be accredited to R.I. Mehr, and 66 per cent of the total work involved is also to be accredited to him.

In the past, each author has been able to blame the mistakes in the book on the other. The new division of work in this edition means that Osler can blame 80 per cent of them on Mehr while Mehr can insist that 100 per cent of them are in the Osler 20 per cent.

In this edition, as in the last, *Modern Life Insurance* stands as the only college text—and practically the only book of any kind—that integrates

the treatment of life and health insurance into one field, "income insurance,"¹ a concept toward which the industry is moving slowly but in which *Modern Life Insurance* is still pioneering, just as it was in 1956 when it won the Elizur Wright Award as "an outstanding, original contribution to the literature of insurance."

Modern Life Insurance also continues to strive to present not only principles and technical facts in the field of income insurance but also to show the application of them to actual use of the product it treats. It gives more space than the majority of texts (and at least as much as any text) to the subject of how to use what it purports to explain in the fields of personal and business financial planning. It does this in recognition of the fact that the vast majority of college students who study the text will deal with insurance in their post-college years as users rather than technicians—and in recognition of the further fact that even those who become technicians will do their job better if they understand the consumer uses of the product.

Perhaps it would not be amiss at this point to quote from the "Foreword" of the first edition: "This book . . . seeks to be as nontechnical as is compatible with accuracy. . . . Although it is hoped the book will prove of interest and value to anyone who seeks to understand or organize his knowledge of one of the largest of all the businesses of America, it has been prepared primarily as a college textbook. Throughout the ensuing pages, the primary audience is assumed to be the college student. . . . The language of the book is primarily his language. The presentation seeks, not to achieve the complexity that is so commonly taken for erudition, but to serve the end of making teaching and learning easier."

Some classes will find the 27 chapters of this text more than can be taught in the typical one-semester course. If the course has been preceded by one in the principles of insurance, chapters 2, 7, 8, 11, 24, 25, 26, and 27 may be omitted. If a non-technical course is desired, chapters 8, 14, 16, 17, 18, 21, 22, 23, and 25 may be eliminated without sacrificing any of the theory of life insurance. Any other combination of chapters may be taken to meet the needs of any given life insurance course because each chapter is self-contained.

Chapter one has been expanded considerably in this edition and will serve as background for a general understanding of the nature and uses of life insurance. Many points made in this chapter are explained in detail later in the text. It is important, therefore, that chapter one not be "over taught," for to do so would consume an undue share of class time. A study of chapter one, however, will facilitate the teaching of many of the other chapters.

Throughout the book, the authors have tried to be impartial. They have

¹ In the last edition this field of insurance was referred to as "accident and sickness." Since that time the Committee on Health Insurance Terminology of the Commission on Insurance Terminology of the American Association of University Teachers of Insurance has agreed to standardize on "health insurance" as the generic term. Inasmuch as one of the authors is a member of that committee, it behooves the book to follow the change in terminology.

sought to analyze the income insurance business in the terms and structure of every business and industry. They have treated it as neither saint nor pariah, recognizing both its strong points and its weaknesses. To those within the business who insist that it should be referred to as something apart from other American businesses, the authors say that much of the demagogic misunderstanding to which the business has been subjected stems from past attempts to set it apart from American business as a whole. That which is *different* is mysterious to the public; and that which is mysterious is ever distrusted.

The authors also should like to point out that they themselves do not always see eye to eye on every interpretation. The result is that a small number of conclusions and even recommendations are not jointly endorsed, while a few other conclusions and recommendations represent the best compromises that could be achieved.

To the extent that this is a co-authorship (80–20 per cent, as we have estimated), it is a true co-authorship. One author has not been responsible for certain portions of the book and the second for other portions. The hand of Mehr is 80 per cent in every line, and the hand of Osler, 20 per cent. Even the style is not wholly that of either author, as can be determined by anyone with no more to do than compare the style of this book with that of those things each author has written separately.

No book is ever written without the help of others—direct and indirect—and many more “others” than space permits to be recognized by name. As authors, we have been preceded by other texts and by trade training courses. To deny that we have drawn upon them would be to admit to a mental vacuum. Both authors are widely acquainted in the business. Neither has hesitated to bring into the discussion sound ideas originally imparted by friends and acquaintances.

For all *these* helps, we can make no direct acknowledgements. There is a limit to human memory. To anyone who feels he originated an idea contained herein, we concede the credit without argument and with sincere thanks. But for some of the more outstanding aids, memory does serve, and we make the following name acknowledgements:

Dr. William T. Beadles, our mainstay through two editions, who read every line, dot, and comma of the manuscript and caught us in many loose statements that would otherwise have gone into print to haunt us forever.

Mr. Floyd Zeigler for his help in doing the arithmetic necessary to change the illustrations in the premium and reserve chapter from 1941 CSO 2 per cent to 1958 CSO 2½ per cent.

Mr. Barnie Abelle for his help in condensing the discussion of the latest income tax law applicable to life insurance companies.

Miss Carol Veihman for typing the manuscript from a rough draft that only an expert in pathfinding could follow.

Mr. Art Kaiser for his help in preparing current material for Chapter 27.

The Aurzella Oslers, junior and senior, for great help in proof-reading and indexing.

Mr. Robert Corley, who read chapter 17 and made suggestions involving change in technical language about which only a lawyer would bother himself.

We can think of no more fitting close for this Foreword than to reword slightly the Foreword of the Revised Edition: The authors wish to say that with all the labor behind, they can declare that writing this text has been fun—fun because both of them are fascinated by the income insurance business. This book goes forth with our earnest hope that to the college student it will prove an interesting clarification of one of America's greatest industries; that for instructors it will make the task of teaching somewhat easier; that it will add something to the cause of nonacademic understanding of life insurance; that it will prove helpful to the agent who aspires to professionalism in the field of life value underwriting and to the layman who seeks to understand an important phase of American business; and that here and there it will help someone to know the business only in order to do a sounder job of planning what is to him of all-vital importance: his family's financial future.

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CHAPTER 1

What Life Insurance Is All About

Life insurance, one of the largest and most important industries in America, is a business with far-reaching social and economic implications. Its first concern is with people's lives. It provides men and women with an institution through which they can systematically create financial security for their families and businesses. It also serves the economy as an important channel through which capital is made available to business and industry. It is a business that affects everyone, directly or indirectly. Thus it is an important field of study that merits the thoughtful attention of all who would consider themselves knowledgeable in business, economics, or finance. Luckily, it is also an interesting business.

1. INTERDEPENDENCE OF SUBJECT MATTER.

The subject of life insurance is one that almost everyone will discuss sooner or later. Fortunately, nearly everybody knows something about it, but unfortunately many who buy it and some who sell it have only a superficial knowledge. Even those who legislate controls or propose reforms for the business are not always sufficiently informed.

What does one need to know to become adequately informed about life insurance? It is essential that he know a few basic principles of law, mathematics, accounting, economics, marketing, finance, business management, statistics, history, and government—all as they apply to life insurance. This seems a rather large order, but actually it is not, because everything is logical, and the pattern as a whole fits quite neatly.

However, in gaining a life insurance education, one problem does present itself. Although the pieces fit together snugly, it is not easy to determine the order in which the pieces should be developed. For example, to understand types of policies thoroughly one should know something about methods of premium computation. But to comprehend premium computations adequately, one must know something about types of policies. This interdependence applies with equal force to other aspects of knowledge about the field.

Thus, since it is necessary to know something of the whole to understand and appreciate the parts, the basic question is where to begin. The bright

young man will say, "With Chapter 1, of course," but that does not solve the problem of Chapter 1 for the authors. Perhaps the best beginning is to give a bird's-eye view of life insurance—a sort of short summary in advance. In other words, it seems that a full understanding of life insurance can be developed best by mapping the forest before beginning a study of the trees. In this way, there is less likelihood of becoming lost in what might appear to be a wild, uncultivated waste.

2. WHY LIFE INSURANCE?

In the great majority of family units, the principal source of income is compensation for work performed by the family head. If this source of income were to be cut off, the family would find it necessary to make economic and social adjustments which might result in serious physical or psychological harm. The mother might have to take outside employment at the expense of her homemaking responsibilities; the children might have to go to work at the expense of their formal education; the family members might have to accept charity from relatives, friends, or social agencies at the expense of their independence and self-respect; and the family standard of living might have to be reduced to a level below that essential for health and happiness.

Illness, death, and old age are three basic threats to the continuation of income from wages or salaries. The first two of these can strike any time during a man's life. And when they do, it is essential that a replacement for the lost income be available if the family is to be spared the hardships of unsatisfactory economic adjustment.

Life insurance is the arrangement through which a man can plan for the continuation of an income if death, disability, or old age destroys his ability to earn a living. Life insurance is used here in its generic meaning to include all forms of insurance designed to protect against loss of income arising from inability to work, whether this be caused by death, accidental injury, sickness, or old age.

In its narrow or specific meaning, life insurance implies income protection in the event of death only. Income protection in event of accidental injury or sickness is covered by the term "health insurance." And the word "annuity" is used to connote income replacement in old age. Perhaps a better generic term for the broader field is *income insurance*; but unfortunately, even this term has its limitations, for it does not imply expense coverage. Dying costs money and illnesses are expensive. Bills from doctors, druggists, nurses, and hospitals mount quickly. Life and health insurance are needed to help pay these expenses. They must be paid not only on behalf of the breadwinner, but also on behalf of members of his family.

3. HUMAN LIFE VALUES.

Thus, the insurance functions of life insurance companies deal with human life values. Unfortunately, too many people tend to think of economic

values solely in terms of tangibles: real estate, equipment, inventories. They do not consider the enormous value of the earning power of human lives. Few young or even middle-aged people own property whose values can even begin to approach the economic value of their lives.

Measure of Human Life Value. The two basic sources of income are capital and labor, or money at work and men at work. Money at work earns interest, rent, or dividends. Men at work earn wages, salaries, or commissions.

If, for example, the owner of the building which houses the campus drug store nets \$300 a month from that operation, the building might be worth \$45,000, assuming the 8 per cent capitalization rate said to be customary for this type of property. Just so, an individual with earning power also has a definite economic value equally measurable in terms of dollars.

Adopting the customary age of 65 as the terminal date of earning power,¹ a man's economic value may be said to be the present value of the total he may anticipate earning, after taxes and personal expenses, between his present age and age 65. For example, a man earning \$10,000 a year after taxes and personal expenses at age 50 will earn a total of \$150,000 by age 65.² His life value, however, is much less than \$150,000 because (1) there is a chance he might not live to be 65 or that disability may cut off his earning power before 65; and (2) a series of payments discounted in advance is never worth what it will total over a period of years. In other words, mortality and interest factors must be considered. Using a modern mortality table and a 3 per cent interest assumption, the value of a 50-year-old man earning \$10,000 net a year is about \$104,000, assuming continuation of the earnings to age 65.³ Life values figured in this manner often have been admitted as expert testimony in court cases involving injury resulting in permanent and total disability.

Life Insurance and Human Life Value. With respect to human life value, life insurance has two functions: (1) to contribute toward its conservation and (2) to protect against financial losses resulting from its destruction.

Life Conservation. Life insurance companies are concerned not only with people's lives but also with situations that affect the value of those lives. Just as fire insurance companies are interested in fire prevention, so life insurance companies are interested in the prevention of accident, disease, and death.

Life insurance has fostered and maintained medical research and health conservation activities toward the end of preserving human life value. The Life Insurance Medical Research Fund, co-operatively supported by many

¹ While earning power often does continue beyond 65, selection of that terminal date for illustration is not wholly theoretical. It is the common age of compulsory retirement set in many industrial pension plans, and it is currently the age at which male Social Security benefits may start. Further, Social Security encourages cessation of earnings at 65 by reducing benefits to those who earn more than a relatively small minimum between that age and 72.

² Obviously the total may vary if his rate of earning varies, but illustrative assumptions can be made only on the basis of current figures.

³ Cf. Chapter 20 for a discussion of the method employed in reaching this figure.

United States and Canadian companies, is one example. It offers fellowships and grants-in-aid for research.

Life insurance companies have been active in the promotion of public health legislation, using their facilities for the distribution of information pertaining to the need for such legislation. The collection and dissemination of information regarding the extra accident and health hazard in certain occupations has tended to emphasize the need for corrective measures. A number of life insurance companies prepare and distribute to the public, health booklets which are designed to promote life conservation. One major company devotes most of its media advertising to health conservation themes.

Protection Against Financial Loss. It is through its services of providing protection against financial losses resulting from the destruction of human life values that life insurance is best known. Only a small part of the total value of human lives, however, is protected by life insurance. Full insurance of value will never be the case, because for the great majority of men, it is financially impossible.⁴

4. AN INVESTMENT MEDIUM.

Health insurance has confined its function to the protection of the family, both from loss of income and from the burden of expenses arising out of accidents or sickness. Life insurance, on the other hand, has extended its services to that of offering a medium for savings and investment. The invasion of this field, however, was purely accidental. It developed as a by-product of the method of financing the cost of life insurance.⁵ This by-product, however, has taken an important place in the sales presentations of most life insurance plans. It is a means by which assets may be accumulated by the policyholder to finance the education of his children and to build a retirement program for himself and his wife. The fact that over 50% of life insurance company benefits are paid each year to the living, in the form of surrender values, annuity and disability payments, policy dividends, and matured endowments, indicates the importance of the investment feature of life insurance in the purchase plans of American policyholders.

The Term and the Cost. Since the investment features of life insurance arise from the method of financing its cost, a few words about the cost of life insurance are in order.

The cost of a life insurance policy depends upon what the insurance company has obligated itself to do under the terms of the contract. The company may obligate itself to pay a death claim only if the insured dies within one year; or it may agree to pay the claim if the insured dies within an extended period of five, ten, or twenty years or before he reaches age 60, 65, or 70. The

⁴ See Chapters 2 and 15.

⁵ Developments in methods of financing health insurance for the aged might lead eventually to the introduction of investment features in health insurance.

company may even agree to pay a death claim no matter when that death occurs, setting no time limit at all. Some contracts provide for payment of a claim not only if the insured dies within a given period, but also upon survival of that period. This latter type of contract is called an endowment policy.

Naturally, the more liberal the promise of the company, the more the insured will have to pay for his policy. Contracts limiting the payment of claims to death that occur within one year are the least expensive type of life insurance. As the term of coverage lengthens, the cost of the insurance increases, reaching its highest cost when the time restriction is eliminated entirely. When a living benefit also is promised to those who survive the death insurance period, the company must charge extra for that additional benefit. Here the shorter the term, the higher will be the cost of the endowment benefit. Why this is true will be seen presently.

The point has already been made that the one-year term policy is the least expensive form of life insurance. The reason is as simple as it is obvious. Assume that 9,575,636 people, aged 25, purchased \$1,000 of insurance for one year. This rather unlikely number of people is selected since it conforms with the number of people assumed to be alive at age 25 in the Commissioners 1958 Standard Ordinary Mortality Table. According to this table (1958 CSO), 18,481 of the group will die during the year.⁶ If the reasonable assumption is made that these deaths are spread evenly throughout the year, then the total contributions from members of the group, to pay for the cost of insurance, can be invested for an average period of six months. At an assumed interest rate of $2\frac{1}{2}$ per cent, a deposit of \$18,254,238 is necessary to accumulate in six months to \$18,481,000, the amount needed to pay \$1,000 each to the beneficiaries of the unfortunate 18,481 who die.⁷ Each member's share of the mortality cost would be \$1.91, which does not include any contribution for the expenses of operating the company. If the policy ran for two years it would cost more because funds would have to be provided to pay the additional 18,732 death claims that would occur throughout the second year. The added burden of \$18,732,000 discounted for one and one-half years would result in an additional \$1.89 for each participant, bringing the total

⁶ The basic data underlying the Commissioners 1958 Standard Ordinary Mortality Table cover the combined ultimate mortality experience of fifteen large life insurance companies that contribute to the annual mortality studies of the Society of Actuaries. These data cover mortality experience during the period between 1950 and 1954 anniversaries, and are loaded to allow a safety margin. From an aggregate point of view, the average safety margin for all ages combined is about 20 per cent, which means that about 20 per cent more deaths per 1,000 are recorded than actually were reported. For a reproduction of the Commissioners 1958 Standard Ordinary Mortality Table and a discussion of mortality tables generally, see Chapter 20.

⁷ As this is written, an interest assumption of $2\frac{1}{2}$ per cent is low, inasmuch as life insurance companies now are earning close to 4 per cent on their investment portfolios. This low interest assumption gives an added safety cushion to that already built into the mortality table, and the two together create surpluses from which policyholders in participating companies receive dividends.

net single premium to \$3.80. Each year added to the term of the policy, of course, adds another year of death claims, and increases the cost of insurance accordingly.

If the term restrictions were eliminated altogether and the policy extended over the entire lives of every member of the group, funds would have to be available to pay death claims over a seventy-five-year period. This is true because under the 1958 CSO Mortality Table, not until age 100 will all the 9,575,636 who enter at age 25 be dead. The last 6,415 live to age 99 and then die in that year. To be prepared to meet all these claims when they mature, the group must collect \$3,252,364,768, assuming an investment return of $2\frac{1}{2}$ per cent.⁸ The single premium mortality cost to each member would be \$339.65.

Therefore, at age 25, the pure cost of \$1,000 of life insurance (the cost without the expense loading and on a single premium basis) will run from \$1.91, on a one-year basis, to \$339.65 on a whole life basis.

Endowment Insurance. Suppose these 9,575,636 people, all of age 25, purchase \$1,000 life insurance policies for a ten-year period with the provision that those who survive the period also would be paid \$1,000. In one respect this contract is similar to the life insurance policy written without time limit: both policies are certain to result in a claim. Since all 9,575,636 policies will mature for \$1,000 claims (to those who are alive at the end of the period and for those who die during the period), enough money must be collected from each policyholder to equal a fund which will grow to \$9,575,636,000 when invested at $2\frac{1}{2}$ per cent. In the whole life contract, interest will make up a larger part of the contribution than it will in the ten-year endowment contract because a longer interest period is involved: seventy-five years rather than ten years. The amount needed in advance to fund the 9,575,636 whole life policies for the group was computed earlier and was found to be \$3,252,364,768. This amount provides only about 34 per cent of the total money needed. Investment earnings make up the other 66 per cent. The money needed to fund the 9,575,636, ten-year endowment insurance contracts amounts to \$7,498,594,000, about 78 per cent of the total money needed. Investment earnings provide the other 22 per cent. If the endowment period were increased to twenty years, the money needed to fund the benefits would be only \$5,907,968,000, with investment income providing the other 38 per cent.

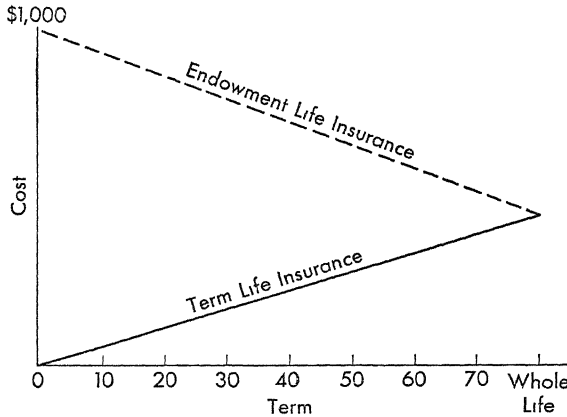
Reduced to an individual basis, the ten-year endowment insurance contract would cost each person \$783.08 at age 25. The twenty-year endowment would cost \$616.98. These compare with \$339.65 for a whole life policy. These costs include only enough to pay policy benefits and do not provide any margin for expenses. Additional investment income, made possible by longer periods in which to earn interest, accounts for the reduction in cost as the term of the endowment increases.

The following graph shows pictorially the effect of the term of a life in-

⁸ How this figure is computed is discussed in Chapter 21.

surance policy upon its cost. The graph is not drawn to exact scale because its purpose is to indicate direction, not magnitude.

Figure 1. Effect of the term upon the cost of insurance.



Three important observations are to be made from this graph.

- (1) The cost of life insurance *increases* with its term.
- (2) The cost of endowment insurance *decreases* with its term.
- (3) Whole life insurance is the most expensive form of term life insurance, and the cheapest form of endowment life insurance.

The first two of these observations already have been explained. The third one, at first glance, seems contradictory. How can one policy be both endowment and term insurance?

Actually, whole life insurance can be looked upon either as term to age 100 or as endowment at age 100. When a whole life policyholder reaches age 100, he is considered to be dead because the mortality table shows all policyholders dead by that age. The rare policyholder who outlives the mortality table is given the face amount of the policy upon completing his first century. What is this payment? Is it a survivorship benefit or is it a death benefit? The facts suggest that it is a hybrid. The funds paid to the centenarian are funds which had been earmarked to pay a death benefit on behalf of the policyholder had he obliged by dying during his 99th year, as was expected of him. These payments, therefore, really are mortality payments to survivors who, according to the mortality table, should be dead.

If the above paragraph seems confusing, do not worry. Just remember that, figured *actuarially*, a whole life policy is term insurance to age 100, since its cost includes death benefits only. Death benefits will have to be paid to all participants, the last of whom is expected to die at age 100. No endowment benefits are figured because no one is expected to survive the period. Viewed *functionally*, however, a whole life policy is an endowment at age 100 because benefits are paid not only to those who die before age 100, but also to

those who survive to age 100. Except for this seeming contradiction in terms, the observation that a whole life policy is the most expensive form of term life insurance and the cheapest form of endowment life insurance already has been explained.

Source of Investment Values to Policyholders. It should be clear now that in all but the short term policies, investment earnings play a significant role in the cost of life insurance. Earlier it was pointed out that the investment values of life insurance were developed as a by-product of the method of financing the premium. Three premium plans are available: the natural premium, the single premium, and the level premium. The natural premium is the only one of the three that offers no investment values to the living policyholder. The natural premium is that charged for yearly renewable term insurance.

Yearly-Renewable Term Insurance. A buyer of life insurance who wants coverage throughout his lifetime, theoretically has the choice of buying a term insurance contract and renewing it as the period expires,⁹ or of buying a whole

TABLE 1.

Pure Cost of \$1,000 One-Year Term Policies *

(1958 CSO 2½%)

<i>Age</i>	<i>Cost</i>	<i>Age</i>	<i>Cost</i>	<i>Age</i>	<i>Cost</i>
25	\$1.91	41	\$ 3.79	57	\$ 15.35
26	1.94	42	4.12	58	16.79
27	1.97	43	4.47	59	18.36
28	2.01	44	4.86	60	20.09
29	2.05	45	5.28	61	21.97
30	2.10	46	5.76	62	24.01
31	2.16	47	6.28	63	26.24
32	2.22	48	6.86	64	28.68
33	2.29	49	7.51	65	31.36
34	2.37	50	8.22	70	49.18
35	2.48	51	9.00	75	72.47
36	2.61	52	9.84	80	108.63
37	2.77	53	10.76	85	159.16
38	2.97	54	11.75	90	225.34
39	3.21	55	12.84	95	346.93
40	3.49	56	14.04	99	987.73

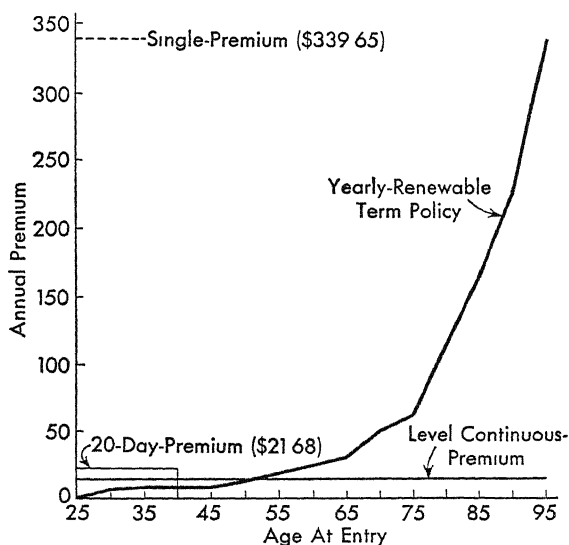
* No additions have been made for the cost of doing business, and, therefore, these premiums will not be representative of those appearing in company rate manuals.

life policy. If he buys the one-year term policy and renews it each year until he dies, no investment values are involved in the policy. The full premium paid each year is used to pay the cost of the insurance for that year. The renewal premium increases each year, of course, to reflect the annual increase in the death rate as age advances. Table 1 shows the *pure* cost of successive one-year

⁹ The choice is theoretical because insurance companies place a limit on the number of times or the age at which the policyholder may renew his contract. The reason for this limitation will be explained later.

term policies for \$1,000 starting at age 25, computed on the basis of 1958 CSO at $2\frac{1}{2}$ per cent. Thus, the pure premium begins at \$1.91 (without the expense loading), and increases each year, reaching \$3.49 in fifteen years, \$12.84 in thirty years, \$49.18 in forty-five years, and \$159.16 in sixty years. The rate of increase is slow during the early years, but picks up later when the year-to-year increases in the death rate become more significant. Figure 2 shows graphically the trend in the net yearly-renewable term rate.

Figure 2. Premiums for \$1,000 whole life insurance written under various plans at age 25; 1958 CSO $2\frac{1}{2}$ % net.



Whole Life Insurance—Single Premium. The other method of obtaining coverage for the whole of life is through a policy issued without time limit. The pure cost of this policy at age 25, as shown earlier, is \$339.65 for each \$1,000 of coverage. This amount, when increased by an expense loading, pays for the contract in full, and is therefore called a single premium.¹⁰

Unlike the yearly-renewable term policy, the single-premium whole life policy contains investment values for the policyholder. These investment values arise from the advance payment of the full premium for coverage written for an extended period, in this case for life. The investment value grows each year from two sources: interest earnings and survivorship benefits. Interest earnings arise from the investment of the advance premium. The survivorship benefit is best explained as follows: When a policyholder dies, the investment

¹⁰ Each premium for the successive one-year term contracts is also a single premium, for it pays in full for the coverage involved. Thus, the single premium for a whole life policy issued at age 99 would be the same as the premium for a one-year term policy issued at age 99, since only one year of coverage is involved in either case.

value in his policy is released and distributed among the surviving policyholders to increase the investment values in their policies. More will be said on this point presently. A death benefit is paid on behalf of those who die. A pro rata share of this benefit is charged against all policies in force. Since in the single-premium whole life policy, interest earnings and survivorship benefits always exceed the cost of the insurance benefit, the investment value will show a net increase each year. For the first five years, the growth is as follows:

<i>Attained Age</i>	<i>Growth of Investment Values</i>
26	\$346.87
27	354.27
28	361.86
29	369.63
30	377.57

A policyholder who purchases a \$1,000 single-premium whole life policy at age 25 for \$339.65, therefore, can cash it in at age 30 for \$377.57 and have a "profit" of \$37.92.¹¹ It should be pointed out that this "profit" ¹² is understated by \$9.99, which is the value of the life insurance protection the policyholder had enjoyed during the five-year period the policy was in force.

An illustrative example should prove most helpful in reviewing how investment profits arise in life insurance policies. For the sake of simplicity, the illustration assumes no loading for expenses, no penalty for early policy surrender, and the payment of all death claims at the end of the policy year in which they become due.¹³ The actuarial assumptions used are the 1958 CSO at 2½ per cent, which produce a net single premium of \$339.65 for \$1,000 of insurance issued at age 25.

At age 25 the policyholder pays a single premium of \$339.65 which at 2½ per cent interest accumulates in one year to \$348.14. Since the 1958 CSO death rate at age 25 is 1.93 per thousand, the fund is decreased at the end of the year by an insurance charge of \$1.93, leaving a total of \$346.21. Note that this amount falls 66 cents short of the \$346.87 investment value indicated at age 26 in the above tabulation of the growth of investment values. Since \$346.87 is needed to fund \$1,000 of whole life insurance at age 26, an additional 66 cents must be provided from some other source. That source is the survivorship benefit, a concept which needs careful explanation.

THE SURVIVORSHIP BENEFIT. Referring to the 1958 CSO Mortality

¹¹ These are figured at *net* rates based on 1958 CSO at 2½ per cent, with no allowance for expenses. The absence of an expense allowance prevents these figures from being comparable to those published by the companies in their rate manuals, but does no harm to the theory.

¹² The term "profit" is put in quotation marks to indicate that it is not used in its pure sense. As used here, it includes interest and survivorship benefits.

¹³ More realism is injected into the picture in Chapter 23. Nothing is lost, however, by ignoring these complications at this point.

Table,¹⁴ it is assumed that out of a group of 9,575,636 people alive at age 25, a total of 18,481 will be dead at age 26, leaving 9,557,155 survivors. Each of the initial 9,575,636 people pays \$339.65 at the beginning of the year, earns \$8.49 interest for the year, and is charged \$1.93 for his portion of the \$18,481,000 paid in death claims, leaving a net balance of \$346.21. For those who die during the year, a death claim of \$1,000 is paid on their behalf, but their claim to the \$346.21 in investment values is relinquished. Since 18,481 claims to \$346.21 are released, a fund of \$6,398,307 ($18,481 \times \346.21) becomes available for the 9,557,155 survivors, making a total of 66 cents for each survivor ($\$6,398,307 \div 9,557,155$).

Table 2 shows the way the investment values in the policy grow and indicates the source of these values year by year. Note the increasing importance of the survivorship benefit with the passing of time. By the time the insured reaches age 63, the survivorship benefit becomes more important than interest earnings as a contributor to the growth of investment values. The increasing importance of the survivorship benefit is explained by the decreasing rate of survivorships at each advancing age level. Note that a simple subtraction of the figure in column 7 from that in column 6 will produce the amount of investment profit earned upon surrender of the contract in the year considered.

The Annual Level-Premium Whole Life. Two methods of purchasing insurance coverage for the full span of life have been discussed: yearly renewable term insurance and single-premium whole life insurance. The first plan offers no investment or savings opportunities (no cash values) whereas the second offers a substantial amount of investment value (large cash values increasing each year). Neither of these plans, however, enjoys much popularity. Yearly renewable term insurance is unpopular because of the distaste of the public for the increasing premium burden, and because of the fear of losing the coverage by default at a later date when the premium jumps out of reach. The single-premium whole life policy is unpopular because few people feel that they can afford the large advance premium required to fund the coverage, and those who can afford it often prefer other investment media for their free capital.¹⁵ What people want is the opportunity to buy their whole life insurance on the installment plan, just as they purchase their homes, automobiles, heavy appliances, and other large capital items. For example, instead of paying a single premium of \$339.65 for a \$1,000 whole life policy, the 25-year-old buyer normally would prefer to pay a series of equal annual payments, either for life or for a limited number of years.

Life insurance was one of the forerunners among products marketed on the installment plan. The installment arrangement as applied to life insurance is known as the level-premium plan. Under this plan, a man aged 25 can purchase a \$1,000 whole life policy for a pure premium of \$12.55 a year,

¹⁴ Reproduced in Chapter 20

¹⁵ Most recently, inflation fears have reduced the attractiveness of fixed dollar investments, thus increasing the popularity of life insurance plans with less emphasis on investment values.

TABLE 2

Investment Values: Single-Premium Life Insurance Policy *

(1958 CSO at 2½%)

<i>Age of Issue. 25</i>			<i>Face Amount. \$1,000</i>			
(1)	(2)	(3)	(4)	(5)	(6)	(7)
<i>Age</i>	<i>Initial Investment</i>	<i>Interest</i>	<i>Mortality Cost</i>	<i>Survivor Benefit</i>	<i>Terminal Investment</i>	<i>Total Premiums Paid</i>
25	339.65	8.49	1.93	.66	346.87	339.65
26	346.87	8.67	1.96	.69	354.27	339.65
27	354.27	8.85	1.99	.72	361.86	339.65
28	361.86	9.04	2.03	.75	369.63	339.65
29	369.63	9.24	2.08	.78	377.57	339.65
30	377.57	9.43	2.13	.82	385.70	339.65
31	385.70	9.64	2.19	.86	394.01	339.65
32	394.01	9.85	2.25	.90	402.51	339.65
33	402.51	10.06	2.32	.95	411.20	339.65
34	411.20	10.28	2.40	1.00	420.08	339.65
35	420.08	10.50	2.51	1.07	429.14	339.65
36	429.14	10.72	2.64	1.15	438.38	339.65
37	438.38	10.96	2.80	1.25	447.79	339.65
38	447.79	11.19	3.01	1.37	457.34	339.65
39	457.34	11.43	3.25	1.51	467.03	339.65
40	467.03	11.67	3.53	1.68	476.86	339.65
41	476.86	11.92	3.84	1.86	486.80	339.65
42	486.80	12.17	4.17	2.07	496.87	339.65
43	496.87	12.42	4.53	2.29	507.05	339.65
44	507.05	12.65	4.92	2.53	517.32	339.65
45	517.32	12.93	5.35	2.82	527.72	339.65
46	527.72	13.19	5.83	3.13	538.21	339.65
47	538.21	13.45	6.36	3.49	548.80	339.65
48	548.80	13.72	6.95	3.88	559.45	339.65
49	559.45	13.98	7.60	4.33	570.17	339.65
50	570.17	14.25	8.32	4.83	580.93	339.65
51	580.93	14.52	9.11	5.44	591.78	339.65
52	591.78	14.79	9.96	6.00	602.61	339.65
53	602.61	15.06	10.89	6.68	613.47	339.65
54	613.47	15.33	11.90	7.43	624.33	339.65
55	624.33	15.61	13.00	8.25	635.19	339.65
56	635.19	15.88	14.21	9.18	646.04	339.65
57	646.04	16.15	15.54	10.20	656.85	339.65
58	656.85	16.42	17.00	11.35	667.61	339.65
59	667.61	16.69	18.59	12.61	678.31	339.65
60	678.31	16.96	20.34	14.01	688.94	339.65
61	688.94	17.22	22.24	15.55	699.47	339.65
62	699.47	17.48	24.31	17.26	709.90	339.65
63	709.90	17.75	26.57	19.13	720.21	339.65
64	720.21	18.00	29.04	21.21	730.39	339.65
65	730.39	18.26	31.75	23.51	740.40	339.65
66	740.40	18.51	34.74	26.06	750.23	339.65
67	750.23	18.75	38.04	28.90	759.85	339.65
68	759.85	18.99	41.68	32.06	769.23	339.65
69	769.23	19.23	45.61	35.50	778.35	339.65
70	778.35	19.46	49.79	39.20	787.21	339.65
71	787.21	19.68	54.15	43.10	795.83	339.65
72	795.83	19.89	58.65	47.17	804.24	339.65
73	804.24	20.11	63.26	51.40	812.48	339.65

Age of Issue. 25				Face Amount. \$1,000		
(1)	(2)	(3)	(4)	(5)	(6)	(7)
Age	Initial Investment	Interest	Mortality Cost	Survivor Benefit	Terminal Investment	Total Premiums Paid
74	812.48	20.31	68.12	55.90	820.56	339.65
75	820.56	20.51	73.37	60.80	828.48	339.65
76	828.48	20.71	79.18	66.23	836.22	339.65
77	836.22	20.91	85.70	72.33	843.73	339.65
78	843.73	21.10	93.06	79.21	850.94	339.65
79	850.94	21.28	101.19	86.83	857.82	339.65
80	857.82	21.45	109.98	95.10	864.35	339.65

* These computations have been rounded off and therefore will not be accurate to the exact penny.

payable for life, or \$21.68, payable for twenty years or until death—whichever occurs first.¹⁶ The level-premium-for-life plan is known technically in the business as “straight life” or “ordinary life,” or, as will be used in this book, “continuous-premium whole life.” The level-premium-for-twenty-years plan is called simply twenty-pay life. Other limited payment plans are written to spread the premiums over periods longer or shorter than twenty years. As will be seen, the shorter the period over which the premium on a whole life policy is to be paid, the greater is the investment character (cash value) of the contract.

Figure 2 reviews some of the premium plans available to the 25-year-old who seeks to purchase coverage for the full span of life. Several other plans are available which, although differing slightly, follow the same general pattern. For example, a whole life paid up at age 65 would take a premium lower than the twenty-pay, but higher than the continuous-premium. Some plans, known as modified life, are written under arrangements whereby the cost is distributed by charging a premium lower than the level-continuous premium during the first few years of the contract and a premium slightly higher thereafter. All these premium plans, except the yearly renewable term plan, involve investment features for the policyholder.

The source of the investment values of the single-premium whole life policy has been explained: interest earnings and survivorship benefits. These factors also account for the investment aspects of the other whole life insurance premium payment plans.

THE TWENTY-PAYMENT WHOLE LIFE. The rate of growth of investment values in the twenty-pay whole life policy and the amounts contributed by each of the growth factors can be observed in Table 3. The column labeled *Initial Investment* is the investment value of the policy at the end of the previous year increased by the payment of the annual level premium for the current year.

¹⁶ These premium charges are based on 1958 CSO at 2½ per cent, and since they do not include an expense loading they will not be comparable to the premiums quoted in the rate manuals of the various companies. How they are computed will be explained in Chapter 21.

The actuarial assumptions used in preparing this illustration are the same as those used in the preparation of Table 2 illustrating the single-premium whole life: premiums are paid at the beginning of the year; claims are paid at the end of the year, there is an interest of $2\frac{1}{2}$ per cent; the 1958 CSO Mortality Table is used; and there is no loading for expenses.

Note in this policy that the pure cost of insurance (mortality costs) exceeds the total of interest and survivorship benefits for each of the first three years. It takes three more years to recoup these losses so that the policy will show no net investment gain until the seventh year.¹⁷

THE CONTINUOUS-PREMIUM WHOLE LIFE. Table 4 indicates the rate of growth of investment values in the continuous-premium whole life policy. In this contract the pure cost of insurance exceeds the combined total of interest and survivorship benefits during each of the first six years. It takes the next six years to recoup the losses so that the policy does not show a net investment profit until the thirteenth year.¹⁸

TABLE 3.

Investment Values in the 20-Payment Whole Life Policy *(1958 CSO at $2\frac{1}{2}\%$)

<i>Age of Issue: 25</i>				<i>Face Amount \$1,000</i>			
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8) <i>Total</i>
<i>Age</i>	<i>Premium</i>	<i>Initial Investment</i>	<i>Interest</i>	<i>Mortality Cost</i>	<i>Survivor Benefit</i>	<i>Terminal Investment</i>	<i>Premiums Paid</i>
25	21.68	21 68	54	1.93	.03	20 32	21 68
26	21.68	42 00	1 05	1.96	.08	41 17	43 36
27	21 68	62.85	1 57	1.99	.12	62 55	65.04
28	21 68	84.23	2 10	2.03	.17	84 48	86.72
29	21 68	106 16	2.65	2 08	.22	106 95	108 40
30	21 68	128 63	3 21	2 13	.27	129 99	130.08
31	21 68	151 67	3 79	2 19	.33	153 60	151.76
32	21 68	175 28	4 38	2.25	.40	177 81	173 44
33	21 68	199 49	4 98	2.32	.47	202 63	195.12
34	21.68	224 31	5.60	2 40	.54	228.06	216 80
35	21.68	249 74	6.24	2.51	.63	254 10	238 48
36	21.68	275.78	6 89	2.64	.74	280 77	260 16
37	21.68	302.45	7 56	2.80	.86	308 07	281 84
38	21 68	329 75	8 24	3 01	1.01	335 99	303 52
39	21 68	357 67	8.94	3.25	1.18	364 54	325.20
40	21.68	386 22	9 65	3.53	1.38	393 73	346.88
41	21.68	415 41	10.38	3 84	1.62	423 58	368 56
42	21 68	445 26	11 13	4 17	1.89	454 11	390.24
43	21.68	475.79	11 89	4.53	2.19	485 34	411.92
44	21.68	507.02	12.67	4.92	2.54	517 32	433.60

¹⁷ Actually, there are no real losses during the first years since the policyholder has the benefit of insurance which is worth more than the indicated loss

¹⁸ Remember these are net figures only and do not include an expense loading. Therefore, they are not comparable with rates and values shown in company premium manuals.

<i>Age of Issue 25</i>				<i>Face Amount* \$1,000</i>			
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
<i>Age</i>	<i>Premium</i>	<i>Initial Investment</i>	<i>Interest</i>	<i>Mortality Cost</i>	<i>Survivor Benefit</i>	<i>Terminal Investment</i>	<i>Total Premiums Paid</i>
45		517.32	12.93	5.35	2.82	527.72	433.60
46		527.72	13.19	5.83	3.13	538.21	433.60
47		538.21	13.45	6.36	3.49	548.80	433.60
48		548.80	13.72	6.95	3.88	559.45	433.60
49		559.45	13.98	7.60	4.33	570.17	433.60
50		570.17	14.25	8.32	4.83	580.93	433.60
51		580.93	14.52	9.11	5.44	591.78	433.60
52		591.78	14.79	9.96	6.00	602.61	433.60
53		602.61	15.06	10.89	6.68	613.47	433.60
54		613.47	15.33	11.90	7.42	624.33	433.60
55		624.33	15.60	13.00	8.25	635.19	433.60
56		635.19	15.88	14.21	9.18	646.04	433.60
57		646.04	16.15	15.54	10.20	656.85	433.60
58		656.85	16.42	17.00	11.34	667.61	433.60
59		667.61	16.69	18.59	12.60	678.31	433.60
60		678.31	16.95	20.34	14.01	688.94	433.60
61		688.94	17.22	22.24	15.55	699.47	433.60
62		699.47	17.48	24.31	17.25	709.90	433.60
63		709.90	17.74	26.57	19.13	720.21	433.60
64		720.21	18.00	29.04	21.21	730.39	433.60
65		730.39	18.26	31.75	23.50	740.40	433.60
66		740.40	18.51	34.74	26.06	750.23	433.60
67		750.23	18.75	38.04	28.90	759.85	433.60
68		759.85	18.99	41.68	32.06	769.23	433.60
69		769.23	19.23	45.61	35.50	778.35	433.60
70		778.35	19.45	49.79	39.19	787.21	433.60
71		787.21	19.68	54.15	43.09	795.83	433.60
72		795.83	19.89	58.65	47.16	804.24	433.60
73		804.24	20.10	63.26	51.39	812.48	433.60
74		812.48	20.31	68.12	55.89	820.56	433.60
75		820.56	20.51	73.37	60.78	828.48	433.60
76		828.48	20.71	79.18	66.21	836.22	433.60
77		836.22	20.90	85.70	72.30	843.73	433.60
78		843.73	21.09	93.06	79.18	850.94	433.60
79		850.94	21.27	101.19	86.80	857.82	433.60
80		857.82	21.44	109.98	95.06	864.35	433.60

* These computations have been rounded off and therefore will not be accurate to the exact penny.

Perhaps it should be emphasized at this point that this policy actually yields investment profits each year. In the early years, these profits are used to pay part of the cost of insurance. Since interest earnings and survivorship benefits together increase at a faster rate than the cost of insurance, a point will be reached when the annual profit will exceed the cost of insurance for the year. At this point the terminal investment value of the policy will increase faster than total premiums paid. And before too many years, the investment value will become greater than the total premium paid. When this final stage is reached, the policy is said to produce a net investment gain. But investment

TABLE 4.

**Investment Values in the Continuous Premium
Whole Life Policy ***

(1958 CSO 2½%)

<i>Age of Issue, 25</i>				<i>Face Amount \$1,000</i>			
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
<i>Age</i>	<i>Premium</i>	<i>Initial Investment</i>	<i>Interest</i>	<i>Mortality Cost</i>	<i>Survivor Benefit</i>	<i>Terminal Investment</i>	<i>Total Premiums Paid</i>
25	12.55	12.55	.31	1.93	.02	10.95	12.55
26	12.55	23.50	.58	1.96	.04	22.17	25.10
27	12.55	34.72	.86	1.99	.06	33.66	37.65
28	12.55	46.21	1.15	2.03	.09	45.43	50.20
29	12.55	57.98	1.45	2.08	.11	57.46	62.75
30	12.55	70.01	1.75	2.13	.14	69.77	75.30
31	12.55	82.32	2.05	2.19	.18	82.37	87.85
32	12.55	94.92	2.37	2.25	.21	95.25	100.40
33	12.55	107.80	2.69	2.32	.25	108.43	112.95
34	12.55	120.98	3.02	2.40	.29	121.89	125.50
35	12.55	134.44	3.36	2.51	.34	135.63	138.05
36	12.55	148.18	3.70	2.64	.39	149.63	150.60
37	12.55	162.18	4.05	2.80	.45	163.88	163.15
38	12.55	176.43	4.41	3.01	.53	178.36	175.70
39	12.55	190.91	4.77	3.25	.62	193.05	188.25
40	12.55	205.60	5.14	3.53	.73	207.94	200.80
41	12.55	220.49	5.51	3.84	.85	223.01	213.35
42	12.55	235.56	5.88	4.17	.99	238.27	225.90
43	12.55	250.82	6.27	4.53	1.14	253.70	238.45
44	12.55	266.25	6.65	4.92	1.32	269.31	251.00
45	12.55	281.86	7.04	5.35	1.52	285.08	263.55
46	12.55	297.63	7.44	5.83	1.75	300.99	276.10
47	12.55	313.54	7.83	6.36	2.01	317.03	288.65
48	12.55	329.58	8.24	6.95	2.31	333.18	301.20
49	12.55	345.73	8.64	7.60	2.65	349.42	313.75
50	12.55	361.97	9.04	8.32	3.04	365.74	326.30
51	12.55	378.29	9.45	9.11	3.51	382.15	338.85
52	12.55	394.70	9.86	9.96	3.96	398.57	351.40
53	12.55	411.12	10.27	10.89	4.51	415.02	363.95
54	12.55	427.57	10.68	11.90	5.13	431.49	376.50
55	12.55	444.04	11.10	13.00	5.82	447.96	389.05
56	12.55	460.51	11.51	14.21	6.59	464.40	401.60
57	12.55	476.95	11.92	15.54	7.47	480.80	414.15
58	12.55	493.35	12.33	17.00	8.45	497.13	426.70
59	12.55	509.68	12.74	18.59	9.54	513.37	439.25
60	12.55	525.92	13.14	20.34	10.77	529.50	451.80
61	12.55	542.05	13.55	22.24	12.13	545.49	464.35
62	12.55	558.04	13.95	24.31	13.64	561.32	476.90
63	12.55	573.87	14.34	26.57	15.32	576.97	489.45
64	12.55	589.52	14.73	29.04	17.20	592.42	502.00
65	12.55	604.97	15.12	31.75	19.29	607.63	514.55
66	12.55	620.18	15.50	34.74	21.62	622.56	527.10
67	12.55	635.11	15.87	38.04	24.23	637.18	539.65
68	12.55	649.73	16.24	41.68	27.15	651.44	552.20
69	12.55	663.99	16.60	45.61	30.34	665.32	564.75
70	12.55	677.87	16.94	49.79	33.79	678.82	577.30

Age of Issue. 25					Face Amount \$1,000		
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Age	Premium	Initial Investment	Interest	Mortality Cost	Survivor Benefit	Terminal Investment	Total Premiums Paid
71	12 55	691 37	17 28	54 15	37 47	691 97	589.85
72	12 55	704 52	17.61	58 65	41 33	704 81	602 40
73	12 55	717 36	17.93	63 26	45 38	717 41	614 95
74	12.55	729 96	18 24	68 12	49 71	729 80	627.50
75	12.55	742 35	18 55	73 37	54 43	741 97	640.05
76	12 55	754.52	18 86	79 18	59.69	753 89	652 60
77	12 55	766 44	19 16	85 70	65 60	765 50	665.15
78	12 55	778.05	19 45	93 06	72 28	776.72	677.70
79	12.55	789 27	19 73	101 19	79 68	787.49	690 25
80	12.55	800 04	20.00	109.98	87.74	797 80	702.80

* These computations have been rounded off and therefore will not be accurate to the exact penny.

gains are achieved at any point. For example, assume that the policy in Table 4 is terminated at the end of the fourth year. A loss of \$4.77 is indicated. But since the policyholder has had four years of insurance protection worth \$7.91, he has had, in effect, a net gain of \$3.14.

The Decreasing-Protection-Increasing-Investment Concept. Some authorities prefer to ignore the survivorship benefit in explaining investment values of life insurance. Instead, they choose to couch their explanation in terms of a decreasing amount of protection coupled with an increasing amount of investment. Under this concept the amount-at-risk decreases each year as the investment value increases.¹⁹ For example, in the \$1,000 single-premium whole life policy issued at age 25, the initial investment value is its single premium of \$339.65. The amount-at-risk would then be \$660.35 (\$1,000 — 339.65). At 2½ per cent this investment of \$339.65 accumulates in one year to \$348.14. At the rate of \$1.93 a thousand, the cost of the \$660.35 at risk would be \$1.27 which, when charged against the policy, will produce an investment value of \$346.87 at the end of the first year, the value shown in Table 2. For an illustration, reference is made to Table 4 which shows an initial investment of \$134.44 at age 35. Invested at 2½ per cent, this yields \$3.36 for the year. The amount-at-risk for that year is the face of the policy (\$1,000) less the initial investment (\$134.44), or a total of \$865.56. At a rate of \$2.51 per \$1,000, the insurance cost for the \$865.56 at risk under this policy would be \$2.17. Adding the \$3.36 interest to the \$134.44 initial investment and subtracting the mortality cost of \$2.17, a terminal investment of \$135.63 is produced. ($\$135.63 = \$134.44 + \$3.36 - \2.17). Although ar-

¹⁹ The amount-at-risk is the difference between the death value of the policy (face value) and the living value of the policy (cash value). It is the amount by which death will increase the value of the policy. The amount-at-risk on a \$1,000 policy having a cash value of \$300 would be \$700. (To be technically correct, the policy reserve rather than its cash value should be used, but for purposes of the discussion at this point, use of the cash value is sufficient.)

rived at differently, this is the same figure shown in Table 4 for the terminal investment value at age 35. Under the survivorship concept, the figure was reached by adding both the interest earnings and the survivorship benefits to the initial investment and then subtracting the cost of \$1,000 of insurance: $\$134.44 + (3.36 + .34) - 2.51 = \135.63 .

The principal difference between the breakdown of figures produced under the decreasing-term-increasing-investment concept and that produced under the survivorship concept, is that what one method shows as a survivorship benefit, the other shows as a reduction in mortality cost. Naturally, the interest earnings will be identical in each case. Under the survivorship concept, it is assumed that the amount of life insurance protection in force is a level \$1,000 throughout the life of the contract. When a policyholder dies, his beneficiaries are paid the \$1,000 from company "mortality funds." The pre-death cash value of the policy is terminated when the policy matures as a death claim. The cash values of the policies held by the surviving policyholders are increased as a group by the amount released by the deceased policyholders. Under the decreasing-protection concept, it is assumed that the amount of life insurance protection decreases each year throughout the life of the contract to the same degree that the cash value increases. When a policyholder dies, his beneficiaries are paid \$1,000, part of which comes from "mortality funds" and the remainder from the predeath cash value of the policy.

Although the decreasing protection concept is a useful tool for explaining the investment character of a life insurance policy, the survivorship concept is technically the correct one. The decreasing protection concept has the psychological advantage of not making it appear that there has been a forfeiture of predeath cash values. And from the standpoint of the individual policyholder, the concept is quite logical. If his \$1,000 policy has a cash value of \$339.65, he is worth only \$660.35 more dead than alive. Thus he finds it easy to reason that his death protection is not \$1,000, but only \$660.35.

Termination or Transfer of Cash Value upon Insured's Death. The assumption, however, that death claims are paid in part from cash values and in part from "mortality funds" has led to confused thinking and conflicting court opinions. The policyholder has a right to have either the cash value before death or the face amount at death paid under his policy, but never both. The actuarial fact is that cash values die with the policyholder, and along with them so should any rights, actual or potential, held by anyone else in these cash values. The beneficiary is paid entirely from "mortality funds," no part of which represents any predeath interests of the policyholder. And, therefore, when the beneficiary is other than the insured or his estate, no part of the death benefits should be available to meet the insured's predeath obligations.

Failure of the Commissioner of Internal Revenue to appreciate this fact has led him, in a number of cases, to demand that the beneficiaries pay from life insurance proceeds any income tax deficiencies existing when an insolvent insured dies. The Commissioner, arguing that these beneficiaries are liable as

transferees of the entire death proceeds, has been successful in convincing the tax courts of the logic of his position, but has been less successful in the United States Courts of Appeals. The Second Circuit in *Rowan v. Commissioner*²⁰ went along with the Commissioner on his contention that the beneficiary was a transferee but only for an amount equal to the predeath cash surrender values. The Courts of Appeals for the Third, Fifth, and Seventh Circuits have agreed with the Second Circuit on this interpretation.²¹ The Third Circuit in the Bess case had this to say: "It is therefore not realistic here. . . . to view Bess's death as wiping out the loan or surrender values. Bess's death was merely a condition on the occurrence of which the loan or surrender values of the policies no longer were payable to him but became merged in the larger values which the insurance companies were obligated to pay Mrs. Bess."

But the Sixth Circuit logically took issue with this view. In *Stern v. Commissioner*²² the court said: ". . . it appears to us that, upon the death of the insured, the cash surrender values no longer existed. To say that the cash surrender values on the death of the insured become merged with the proceeds of the policies paid to the widow is figurative. . . . The cash surrender values were not part of the proceeds of the insurance policies paid to the widow, and to hold otherwise would seem to transform plain language to the advantage of the tax-gathering authority, and to the loss of the widow."

The United States Supreme Court in reviewing the Bess case²³ attempted to clear up the confusion by making a distinction between what it considers to be the technical relationship among the parties and what it considers to be the practical relationship for certain economic purposes. On this point it concluded: "Thus in economic reality, the insurer pays the beneficiary the insured's fund, plus another amount sufficient to perform the insurer's promise to pay the proceeds on the insured's death. Therefore, we hold that . . . there was a transfer of property from the insured to Mrs. Bess."²⁴

This decision of the Supreme Court tends to favor the decreasing-protection-increasing investment concept as a logical economic explanation of life insurance cash values while at the same time recognizing the technical accuracy of the survivorship concept.

Cash Values as a Fund. It might appear from a reading of these pages that the investment or cash value of a life insurance policy is a specific fund belonging to the policyholder and held in trust for him by the insurance company. Such an appearance, however, is only illusory. A life insurance policy is a contract between the insured and the insurer under which the insurer agrees

²⁰ 215F. (2nd) 641.

²¹ *U.S. v. Bess* 243F. (2nd) 675, *U.S. v. Trucex*, C. A.-5, 223F. (2nd) 229; and *U.S. v. New*, C. A.-7, 217F. (2nd) 166.

²² 242F. (2nd) 322.

²³ *U.S. v. Bess*, 357 U.S. 51.

²⁴ A full discussion of creditors' rights is found in Chapter 8. The purpose of the present discussion is solely to indicate the confusion in the source of funds for the payment of claims.

to make payments under certain stipulated conditions. Thus, the insurance company agrees to pay a cash surrender value to the policyholder in lieu of paying the face amount of the policy to his beneficiaries after his death. To compel the insurer to pay him the cash surrender value, the insured must only surrender the policy. Until this condition is fulfilled and payment is made to the policyholder, all funds held by the company are company funds. None of these assets belongs to the policyholder. Of course, the company must report these conditional promises as liabilities and evaluate them properly on its financial statement.²⁵

Since the policyholder can borrow against, assign, or pledge his right to collect the cash value, this right must, of course, be considered by him as a part of his assets. The policyholder's asset is not a pro rata share in his company's funds as is so often loosely suggested. Instead, it is the right to collect funds from the company upon giving up the right to have his beneficiaries paid a larger amount when he dies. That this distinction is subtle is illustrated by the words of the United States Supreme Court.²⁶ "But the courts have long recognized that the surplus of paid premiums accumulated to make up the cash surrender value should be treated for some purposes as though in fact a 'fund' held by the insurer for the benefit of the insured." *In re McKinney*,²⁷ a case cited by the United States Supreme Court, the judge stated: "Though this excess of premiums paid is legally the sole property of the company, still in practical effect, though not in law, it is the moneys of the assured deposited with the company in advance to make up the deficiency in later premiums. . . . So long as the policy remains in force, the company has not practically any beneficial interest in it, except as its custodian, with the obligation to maintain it unimpaired and suitably invested for the benefit of the insured. This is the practical, though not the legal, relation of the company to this fund."

Thus, although the courts recognize that life insurance cash values are not funds held in trust by the companies for the policyholders, they have found it helpful to view them as such. It would seem that the beginning student of life insurance should be granted this same privilege.

Policy Dividends. Earlier, in figuring the cost of life insurance, two assumptions were made: (1) Mortality will conform to the 1958 CSO Table, and (2) interest will be earned at the rate of $2\frac{1}{2}$ per cent. Both of these assumptions are conservative. A margin is built into this mortality table so that there will almost always be fewer deaths than it indicates. For example, at age 25 the basic data underlying the 1958 CSO Table indicate only .93 deaths per 1,000 whereas the mortality table shows 1.93 deaths per 1,000, a margin of 107.5 per cent.²⁸ And history shows that only five times since the turn of the

²⁵ See Chapter 23 for a discussion of the problems of evaluating liabilities.

²⁶ *U.S. v. Bess*, 357 U.S. 51.

²⁷ 15 Fed. 535, 537.

²⁸ The percentage margin varies from age to age. It is highest at age 10, where it is 236.4 per cent and lowest at age 0, where it is 11.8 per cent. From age 64 to 93 it remains at 15 per cent. See Chapter 20 for a further discussion of mortality margins.

century have the life insurance companies as a group earned interest, net after taxes, at a rate of less than 3 per cent a year.²⁹ Never during this period have they earned less than 2.88 per cent.

When an insurance company experiences a lower death rate or a higher interest rate than it assumes in calculating its premium, an addition to its surplus will result. A third source of surplus is expense savings. An expense allowance is added to the pure premium to produce the premium charged the policyholder. If actual expenses turn out to be less than those allowed in the rate, the difference is reflected in the surplus. This surplus is available for dividends. Over two-thirds of the life insurance in force in United States companies is written on a participating basis, which means that the policyholder participates in the surplus of the company through an annual policy dividend. Under the terms of his contract, the participating policyholder has several optional methods by which he may take his dividend. These options are discussed in Chapter 10.

5. SOCIAL AND ECONOMIC VALUES.

In addition to contributing to the economy by preserving human life values and protecting against the financial consequences of their loss, life insurance also aids in financing business, industry, and government.

Financing Business and Industry. Expanding production is necessary to the maintenance of full employment and a healthy economy. A growing economy needs capital to finance new factories, machines, production and marketing research, materials, and labor.

There was a stage in the historical development of the American economy when the bulk of such financing could be done by individual financiers or by a small combination of them. Today the economy is too large and complex to depend on that type of financing for the major part of any necessary expansion. Instead, it must turn to the small saver; it must get its financing from millions of investors instead of a few. Thus it has looked more and more to public offering of corporate securities.

Life insurance companies, by investing funds that flow to them from their many policyholders, have become a principal source of capital for the economy. They make available to industry the savings of millions who themselves never would or could invest directly in business. Further, by creative selling, life insurance companies encourage many to save who would not do so in any other form. Millions who have few other savings or investments of any kind have created sizable savings in the cash values of their life insurance. These savings have been put to work in American business and industry. Without the offsetting savings of the masses, the financing of business expansion would entail methods which would be highly inflationary. Thus, life insurance makes a contribution toward counteracting inflation.

In effect, life insurance forms a huge investment pool of the combined savings of over 100,000,000 Americans, a pool to which business and industry

²⁹ 1946; 1947, 1948, 1949; 1951.

can turn for money to aid in expansion. Today this investment pool—the combined assets of the legal reserve companies of the country—amounts to well over \$100,000,000,000. Approximately 44 per cent of this total is invested in securities of business and industry.³⁰

Other Financing. In addition to supplying capital funds to business and industry, life insurance is an important source of financing in a number of other important economic activities. It has invested about \$7,000,000,000 in United States government securities and over \$3,800,000,000 in securities of other governmental units. Its total investment in mortgages is well over \$35,000,000,000.

The investment departments of the life insurance companies are always seeking the most favorable investment return available, subject, of course, to the standards of solvency which they must maintain. They have long been a major source of funds for those who seek to borrow for legitimate investment uses. After the speculative period in railroad financing had passed and there was a need for capital funds to spread rails over the country, life insurance funds were an important source of railroad capital. When the South experienced expansion in the late 1930's, life insurance funds flowed into that region at a faster rate than into other sections of the country. During World War II, when there was a vastly increased need for financing the government, United States government securities became a large portion of life insurance company investments. When, in the postwar period, business and industry had a heavy demand for capital funds to be used in retooling for civilian production, corporate securities became a leading channel for new investment of life insurance funds. In this same period, when home building started on a record-breaking expansion, mortgage financing took the lead in life insurance company investing. As the Southwest and Pacific states began expansion in the late 1940's and early 1950's, life insurance capital increased its flow into that area.

Life insurance is one of the most important sources of capital funds for the economy, and the growth of the basic industries of the country has been aided substantially by the investment in them of funds paid in by policyholders.

Stabilization of Business. In addition to the support that life insurance gives to business and industry in America through its investment in their securities, it tends to stabilize business structure in three ways: (1) by reducing risk, (2) by establishing credit, and (3) by reducing the necessity of liquidation under unfavorable circumstances.

Small business units are predominant in the American economy: the sole proprietorship, the two- or three-man partnership, and the small, close corporation (often called "the incorporated partnership"). One of the major risks in the small business is the loss of a principal or key figure in the enterprise, either by death or disability. The chance of business liquidation after

³⁰ Approximate distribution of funds invested in securities of business and industry: railroad bonds, 8 per cent; public utility bonds, 34 per cent, industrial and miscellaneous bonds, 50 per cent, stocks, 8 per cent. It should be emphasized that this is an approximate distribution and that it varies from year to year.

such a loss is high.³¹ Life insurance can be used to reduce and even eliminate this risk. By doing so, it not only stabilizes the business structure but also makes starting and investing in new business more attractive.

Life insurance also stabilizes a business by enhancing its credit standing. Policies on the lives of owners of a business are not only a source of liquid capital themselves but also are a source of an improved credit rating for the business. Particularly in the smaller business, suppliers are more willing to advance credit if they know that, should the owner or key figure in that business die or become disabled, it will not be necessary to liquidate the business to obtain the cash to pay off the bills.

Social Contributions. The economic contributions of life insurance and its social contributions are interwoven. Whatever life insurance does to stabilize business and industry and whatever it contributes to the expansion necessary to maintain full employment are social as well as economic contributions.

Life insurance also makes a number of other important contributions to social welfare. Foremost among these contributions is the prevention of economic want. Emergencies calling for more money than the individual has in current income are socially as well as personally disturbing. Such emergencies arise in case of disability, old age, and death. Life insurance, by encouraging people to plan for these contingencies and to save systematically, serves in all these crises.

The prevention of economic want enables life insurance to contribute to the social organization of the nation by assisting in the maintenance of the family unit, the basis of the social structure. Life insurance tends to hold the family together in periods of financial emergency by providing it with a backlog of funds which make it less necessary for the family to scatter among relatives or appeal to charity for support. This is true, whether the cause of the financial emergency be disability, death, or old age.

Finally, life insurance helps families plan for the education of their children. Many young men and women have attended college on the proceeds or cash values of life insurance.

6. SIZE AND GROWTH OF THE INDUSTRY.

Helpful to an appreciation of the role life insurance plays in the American economy is an understanding of its size and growth.

Size. In the aggregate, about 125,000,000 people are paying over \$12,-000,000,000 annually for some \$500,000,000,000 of life insurance.³² As a

³¹ What these problems are and how life insurance solves them will be discussed in Chapter 18.

³² Primary source of current statistics on life insurance is the *Life Insurance Fact Book* (New York: Institute of Life Insurance, annual). Primary sources of current statistics on health insurance are *The Extent of Voluntary Health Insurance Coverage* (New York: the Health Insurance Council) and *Source Book of Health Insurance Data* (New York: Health Insurance Institute). Statistics on the national economy will be found in the *Statistical Abstract of the U S* (Washington, D C : Department of Commerce, annual). These works are the primary source of all statistics used in this section

group, they have accumulated in savings close to \$90,000,000,000 through this institution. In addition, they are paying more than \$6,000,000,000 a year for health insurance.³³

Life insurance is the nation's most popular single savings medium. Life insurance reserves³⁴ are almost double the value of the savings accounts in savings and loan associations,³⁵ more than two and a half times the savings in mutual savings banks,³⁶ almost one and a half times the savings in commercial banks,³⁷ more than seventy times the redemption value of United States savings bonds held by individuals, and over twenty times the value of share capital and members' deposits in credit unions.

Over 500,000 people make their living in the life and health insurance business.

Growth. Some appreciation of the position of life insurance in the economy can be gained from a consideration of its growth over the past decade alone. Common measurements of size in the insurance business are amounts of insurance "in force,"³⁸ assets, and income or receipts. For health insurance, common measurements are number of people covered and premiums earned.

Rate of Growth. During the decade ending 1958, the total life insurance in force has increased 130 per cent while assets have increased 80 per cent.³⁹ The income or receipts of the life insurance companies are made up of premiums collected plus investment and other income. In the same decade, premium income increased by 82 per cent.⁴⁰ Investment and other income increased by 74 per cent. The most remarkable growth occurred in health insurance where the number of persons covered nearly doubled and the premiums paid increased nearly 500 per cent.

The above percentages indicate growth in terms of current dollars, and thus reflect the inflation that took place during the period. In terms of constant dollars, life insurance in force increased 83 per cent, assets about 46 per cent, premium income about 47 per cent, and investment and other income about 35 per cent.

Share of Growth. An analysis of the extent to which life insurance as an

³³ This figure includes payments made not only to life insurance companies but also to other types of organizations furnishing protection against hospital expenses, surgical expenses, medical expenses, and loss of income.

³⁴ Plus dividends left to accumulate, minus premium notes and policy loans

³⁵ Savings accounts, deposits, and investment certificates, minus shares pledged against mortgage loans and investments by the United States government.

³⁶ Time deposits.

³⁷ Time deposits of individuals, partnerships, and corporations.

³⁸ The face value of outstanding life insurance policies that are in full force and effect.

³⁹ The greater increase in "in force" than in assets is a result of two things: (1) the large volume of new business sold during the same years, which has not yet built up substantial cash values, and (2) a trend during the period to a higher percentage of sales of term insurance in all its forms, including group.

⁴⁰ This is the increase for life insurance and annuities only. Premium income for health insurance written by life insurance companies increased by more than 300 per cent.

industry has shared in the growth of the economy is necessary to complete the picture. During the same ten-year period that life insurance in force increased by about 130 per cent, the gross national product and national income ⁴¹ rose by about 72 per cent and 69 per cent respectively; disposable personal income ⁴² during this period rose by about 68 per cent; whereas, life insurance premium income increased by about 82 per cent. Savings ⁴³ held by the people outside their life insurance increased by about 70 per cent; whereas, life insurance assets (largely funds being held for future payment under contract to policyholders and their beneficiaries) increased by about 80 per cent. In general, therefore, during the past decade, life insurance has grown at a faster rate than has the economy at large.

Pattern of Growth. The growth of life insurance has been more or less steady despite depression, war, and inflation, with the consequence that life insurance premiums have absorbed more of the disposable personal income during the depression and less during inflation.⁴⁴ While the drop of the percentage of disposable personal income going into life insurance during the postwar inflation years often has been cited as evidence that life insurance has not grown as fast as the economy, the facts would seem to indicate, instead, a degree of stability of growth which is matched by few other business institutions.

7. STABILITY OF LIFE INSURANCE.

Since the social and economic organization is dynamic, it is important to analyze an industry in relation to its ability to adapt to social and economic change.

Perhaps the best answer as to whether or not life insurance can so adapt is the record of the past. It reveals that although there have been company failures, the industry as a whole has maintained an enviable record of stability.

Source of Stability. Two great sources of the stability of life insurance are its diversification of investments and its system of merchandising.

Diversification of Investments. Life insurance applies the principle of diversification of investments not only in the number of different investments it holds, but also in the geographic distribution of those investments, their dis-

⁴¹ The gross national product (often abbreviated GNP) is the sum of all private expenditures for consumption goods and services, gross private investments, and government expenditures. National income, another measure of economic growth, is the GNP less depreciation and indirect business taxes

⁴² Disposable personal income is the national income plus transfer payments less the sum of undistributed profits, corporate taxes, social security tax contributions, and personal taxes.

⁴³ Savings and loan associations, mutual savings banks, time deposits in commercial banks, United States saving bonds, postal savings, and credit unions

⁴⁴ The following ratios of premiums to disposable personal income indicate the fact that life insurance neither expands nor contracts at as fast a pace as does income.

1929—4.0	1937—5.3	1945—3.4	1953—3.6	1957—3.8
1933—7.2	1941—4.3	1949—3.5	1955—3.7	1959—3.9

tribution by types of enterprise, by types of companies, by types of securities, by maturity dates, and by time of purchase.

First, investments of any given life insurance company are spread among industries and enterprises located in different sections of the country in order to minimize fluctuation in value or loss by localized depression.

Second, investments are distributed by type of enterprise. Not only do life insurance companies spread their investments among industrials, utilities, mortgages, real estate, and governments, but also among different industries and different companies within an industry.

Third, life insurance investments are diversified in number. Thousands of different specific investment holdings are in the portfolios of even the relatively smaller companies.

Fourth, life insurance investments are diversified by date of purchase. Companies buy securities day in and day out, year in and year out. The cost of their investment portfolio is an average over both good and bad times. Adverse investment conditions for any one year, or even for a period of several years, cannot do serious damage to a large portfolio.

Finally, life insurance investments are diversified by maturity date. In times of economic distress, investment maturities are available to help handle emergency calls for cash and thereby reduce the chance that other investments will have to be liquidated in depressed markets. As will be seen in the next section, diversified maturity dates, although giving an added margin, are not so important to the stability of life insurance as one would expect.

System of Merchandising. Both the basic nature of the product of life insurance and the method of merchandising it contribute to its stability, perhaps even more than its investment practices.

In the first place, life insurance is a continuing investment for the policyholder. It is not a one-time purchase. The vast bulk of policies is purchased on an annual (as contrasted to single) premium basis. The buyer undertakes a long-term obligation in his budget, and he is subject to some penalty if he drops the obligation: the penalty of loss of insurance protection. Therefore, he strives to keep up his premium payments despite "hard times" for himself or for the economy.

In the second place, life insurance companies use an aggressive merchandising system. Through their agents, they forcefully solicit new business and strongly encourage existing policyholders to continue their premium payments. The agent's income is directly dependent on both the new policies he sells and the old ones that stay in force. The compensation system under which he works penalizes him when policies are dropped.⁴⁵ Therefore, he puts time and effort into bringing in new business and conserving old.

⁴⁵ For explanation of this basic compensation system used in life insurance, cf. Chapter 25. The agent is paid a commission for the sale of new policies and a "renewal" commission each year the policy remains in force. Sometimes these renewal commissions

While periods of economic depression markedly decrease the flow of new money into almost all other enterprises, the basic nature of the life insurance investment, plus the activity of the agent, keeps up the flow of money into life insurance. For instance, the premium income of life insurance in 1929, before the depression, was \$3,350,367,354; while in 1933, in the depths of the depression, it was still \$3,321,797,924. This continuous inflow of new money enables companies to meet cash calls in times of depression without the necessity of liquidating securities at distressed prices. Table 5 shows that during the worst years of the depression, despite the heavy demands for cash and loan values, the total income of the business each year was sufficient to meet all cash calls.

TABLE 5.

**Premium Income, Total Income, and Total Disbursements,
1930-37**

<i>Year</i>	<i>Premium Income</i>	<i>Total Income</i>	<i>Total Disbursements</i>
1930	\$3,524,326,635	\$4,593,973,110	\$3,198,537,056
1931	3,661,105,385	4,850,375,950	3,537,704,954
1932	3,504,255,574	4,653,395,656	3,997,698,360
1933	3,321,797,924	4,622,291,932	3,917,431,410
1934	3,520,984,136	4,785,984,654	3,661,718,746
1935	3,692,127,637	5,072,095,267	3,592,956,321
1936	3,683,487,169	5,180,225,071	3,518,026,585
1937	3,761,745,196	5,257,048,795	3,610,343,044

8. SUMMARY.

The life insurance industry is one of the largest of all industries in America. Its present rate of growth is steady and somewhat greater than the growth of the economy.

The principal functions of life insurance are to protect against the financial consequences resulting from the loss of human life values and to provide a systematic method of accumulating an estate for educating children, meeting financial emergencies, and funding old age security. The investment values of life insurance arise from the method of financing premiums. These values grow each year from interest earnings and survivorship benefits. Dividends are paid to participating policyholders from surplus which arises from savings in mortality costs, expense savings, and excess interest earned.

Both in the protection it offers and the benefits it pays out each year, the life insurance business is a socially and economically stabilizing influence. The assets of the life insurance companies support the basic business, industry, and services of the country and give each policyholder a financial stake

are for an initial period of years only, such as the first nine, increasingly, some type of renewal commission or service fee is being paid as long as the policy is in force. Therefore, when a policy is dropped, the agent loses whatever renewal commissions remain.

in the economy. The stability of life insurance offers safety and security to policyholders and their beneficiaries. Life insurance affects almost every living person in the country.

A business of such size and importance to the social and economic order is one which must be studied if a full understanding of the American economy is to be obtained.

QUESTIONS FOR CLASS DISCUSSION

1. A seven-year-old boy was hit by an automobile. As a result of the injury, he was permanently and totally disabled. The driver of the car was sued for damages. You are called by the attorney for the plaintiff as an expert witness to testify as to the value of this boy's life. Outline the nature of your testimony.
2. Loss prevention should be of as much concern to insurance companies as loss indemnification. Do life insurance companies have as great an incentive for loss prevention as do fire and casualty insurance companies?
3. Why do people insure the value of their homes against loss by fire more adequately than they insure the value of their lives against loss by death?
4. Explain why, when the insured dies, the beneficiary does not collect both the face of policy and the unearned portion of the advance premium which has been paid by the insured.
5. Explain how life insurance companies help to counteract inflation.
6. Are there any economic contributions of life insurance to business and industry which cannot be performed by any other institution? Discuss.
7. Are life insurance cash values a fund held by the insurer for the benefit of the insured?
8. How do you account for the proved stability of life insurance? Is this stability an exclusive advantage of the life insurance industry? Discuss.
9. How do you account for (a) the growth of the life insurance industry over the past decade, and (b) the relatively wide fluctuation in the ratio between life insurance in force and the gross national product over the past decade?
10. Why, in the computation of premium rates, do life insurance companies use both mortality tables that overstate mortality and interest assumptions that understate interest earnings?

CHAPTER 2

The Nature and Handling of Risk

Insurance is a device for reducing some of the risks inherent in the economy. It operates by combining a sufficient number of homogeneous exposure units to make loss predictable. By definition, therefore, risk is a condition precedent to insurance. Consequently, an understanding of the nature and meaning of risk (and of certain matters closely related to it) is necessary to an understanding of insurance.

1. BASIC DEFINITIONS.

Each field of knowledge has its own terminology. Insurance is no exception. Certain terms have several connotations outside the field, and are subject to varying usage even within it. Such variations in usage may not be particularly confusing to one well acquainted with the field; but to the beginning student they can be both a bother and also an unending source of misunderstanding. Therefore, it will help in the understanding of risk and its relation to life insurance if the terms "chance of loss," "risk," "peril," "hazard," and "loss" are carefully defined and differentiated.

Chance of Loss. Chance of loss is an expression of the probability that a loss will occur. It can be measured mathematically as a percentage of the possible number of losses occurring from any given number of exposures to that loss. To put it another way, it is a fraction obtained by dividing the probable number of unfavorable events by the total number of possible events. To illustrate:

A coin has two sides. Tossed in the air, it will come down either "heads" or "tails." Assume that the appearance of "tails" is an unfavorable event; then the probable number of unfavorable events is one, whereas the total number of possible events is two. As a percentage, the probability of an unfavorable event (tails) is 50 per cent. As a fraction, it is $\frac{1}{2}$. As a bet, it is "even money": one to one.

As another example: ¹ Assuming that the appearance of double ones,

¹ The use of this example is no suggestion that insurance and gambling are akin but rather that the throw of honest dice is a perfect example of the law of chance. Insurance is not gambling. In gambling, the risk is created by the transaction; in insurance, the

double sixes, or a one and two combination is an unfavorable event in the first throw of a pair of dice, then what is the chance of loss? There are thirty-six possible combinations in a throw of a pair of dice, but only four of these combinations yield any of the "unfavorable" combinations producing two, three, or twelve. Thus, the probable number of unfavorable events is four, whereas the total number of possible events is thirty-six. Consequently, the chance of loss in the first throw is four in thirty-six—11.1 per cent or $\frac{1}{9}$.²

In illustrations based on tossed coins or thrown dice, it is simple to measure the chance of loss (which is the reason such illustrations were used). In them, the probability is based on logic—including mathematics as a form of logic. But what is the probability that a man now 21 will die before he reaches age 22—or what is the probability that he will die before reaching 65? What are the probabilities involved in loss by premature death, old age, accident, or sickness? It is not possible to measure these with logic. Instead, there must be statistical data—or what is called "empirical probability."

To determine the probable number of persons in any given group who will die at any age, statistics on a large number of lives have to be collected and formulated into tables—"tables of mortality," in the case of life insurance, of "morbidity" in the case of health insurance. By observing the number of deaths out of a sizable group at a given age, the probability of death at that age can be ascertained. Thus, on a mortality table used in the United States at the present time,³ the probable number of persons aged 21 who will die before 22 is 17,655 out of 9,647,694, and the probable number dying before 65 is 2,847,163 out of 9,647,694 alive at 21; hence the probability of death during age 21 is $17,655/9,647,694$ or 1.83 per cent, and during the 44-year period from 21 to 65, $2,847,163/9,647,694$ or 29.5 per cent.

The principal reason for studying chance of loss in insurance is to establish a basis for premium computation. A workable measure of probability is essential to the establishment of a fair and equitable rate for insurance coverage.

Risk. Risk is uncertainty. In the field of insurance, it is the uncertainty of financial loss. If there is certainty that a loss *will* occur, there is no risk; if there is certainty that it will *not* occur, again there is no risk. Risk is a result of the fact that an individual cannot determine definitely what will happen to his property or person at any given time in the future.

risk is reduced by the transaction. For example, until a bet has been placed, there is no chance of losing on the throw of a pair of dice. But with respect to premature death, the risk is there until reduced by insurance. Thus gambling and insurance are opposites since one creates a risk, whereas the other reduces it.

² Gamblers call it "odds," which would be expressed in this case as one to eight *for* or eight to one *against* loss on the first throw. In the game of "craps," the "house" loses if the gambler's first throw yields a seven or an eleven total. Eight different combinations produce seven or eleven; thus the chance of the "house" losing on the first throw is eight in thirty-six—22.2 per cent or $\frac{2}{9}$. In this case, the odds are seven to two *for*, or two to seven *against*, loss on the first throw.

³ 1958 Commissioners Standard Ordinary (CSO), reproduced in Chapter 20.

Death is a certainty; therefore, the risk involved in a life insurance transaction is not *whether* the unfavorable event will occur, but *when* it will occur. From an economic standpoint, it may come too soon, i.e., during the productive years of life. Or it may come too late, i.e., not until long after the ability to earn a living has ceased.

Accident and sickness are not certainties; therefore, the risk involved is not *when* the unfavorable event will occur, but *whether* it will occur. How long disability will last and whether it will be partial or total are also uncertainties and hence risks.

Risk exerts a retarding influence on economic activity. Insurance exists because people prefer a small, certain cost that can be budgeted (the insurance premium) to an uncertain but potentially large loss (the amount of the insurance) that cannot be budgeted.

Degree of Risk. The accuracy with which the occurrence of loss can be forecasted is the basis by which degree of risk is measured. Assume that in any twelve-month period, the chance of illness causing appreciable loss of time from employment in a given occupation to be one in 1,000. If an employer has only one employee, the degree of risk is high because he is unable to predict his loss. His one employee, his entire staff, may be the one in 1,000 who becomes ill, or he may not. For this employer, the degree of risk is absolute (100 per cent of his exposure), even if the chance of loss is low. Since there is no basis for predicting the outcome, uncertainty is complete.

Even with 1,000 employees, the employer could not predict his loss with any reasonable degree of accuracy. He knows from statistics only that, in any year, on the average, one employee should be sick, but he has no assurance that his experience will approximate the average. In fact, his experience is likely to vary widely from the average. Sometimes no employee will be sick, and other times as many as ten or more might be ill simultaneously.

Suppose the employer has 100,000 people working for him. He can expect 100 to become ill. Even if as many as 10 more or 10 fewer actually are ill, he has missed his calculation only by 10 per cent of his prediction, or 0.01 per cent of his exposure. The larger number of employees in his group makes the incidence of employee illness predictable with a greater degree of accuracy. The risk is not entirely eliminated, however, for there is always the uncertainty that the losses will not take place as predicted, i.e., that there will be a deviation of losses incurred from average expected losses.

The degree of risk is measured by the probable variation of actual experience from average expected experience. The lower the probable percentage of variation, the smaller is the degree of risk. As the number of exposures to a peril increases, the less will be the percentage by which actual losses will vary from the average expected losses. The absolute amount of the variation will increase, of course, but the extent of the increase is limited to the square root of the multiple by which exposures are increased.

To illustrate:

Assume that the annual death rate from a given cause is one out of 100. If there is an exposure of 10,000 lives, the average expected deaths will be 100. Actual deaths, however, will equal the average expected deaths only by coincidence. In some years there would be more than 100; in other years, fewer. Assume the variation from the average over the past few years has been 50. This means that the probable number of deaths each year will be between 50 and 150. The area of uncertainty is 100 cases, or 1 per cent of the exposures.

Now if the number of exposures is increased one hundredfold to 1,000,000, the average expected deaths will be 10,000. The probable variation of actual from average expected deaths will also increase, but not one hundredfold. Instead, it will increase only tenfold, 10 being the square root of 100. The probable number of variations from the average expected deaths will now be 500, and the probable number of deaths will lie between 9,500 and 10,500. The area of uncertainty is now 1,000 instead of 100; but whereas 100 was previously 1 per cent of the number of exposures, 1,000 is only one tenth of 1 per cent of the present 1,000,000 exposures.

Thus the area of uncertainty (the degree of risk) grows relatively smaller as the number of exposures increases because as the number of exposures approaches infinity, the maximum probable percentage variation of actual losses from average expected losses approaches zero.

The extent to which future events can be predicted is the measure of risk. As events become more predictable, risk is reduced, irrespective of the chance of loss.⁴

Peril. A peril is anything which may cause a loss. Examples from the field of life and health insurance are accident, sickness, premature death, and old age. Causes of loss (accident, sickness, premature death, old age) are often loosely called "risks." Correctly, *risk* is the uncertainty about the occurrence of a loss, whereas *peril* is the cause of the loss. A study of perils is important to the understanding of life and health insurance. Whereas life insurance policies usually are written to cover death from any peril, health insurance often may restrict income and expense coverages to certain named causes, or to all causes except those specifically excluded.⁵

Hazard. Hazard is a condition that increases the chance of loss arising from a peril. For instance:

An accident may be the ostensible cause of a permanent and total disability, but what was the cause of the accident? It may have been faulty driving attributable to carelessness, poor eyesight, liquor; it may have been a faulty vehicle, with bad brakes, poor lights, defective tires; or it may be bad driving conditions, such as icy roads, glaring sun, poorly marked highways.

⁴ Just like risk, chance of loss also can exert a retarding influence on economic activity. A large chance of loss will discourage business activity more than will a small chance of loss irrespective of the degree of risk involved.

⁵ Exceptions are the suicide clause and the occasional aviation or war clauses found in life insurance policies. For a discussion of the limitations on perils in the health insurance contract, see Chapter 11.

These conditions are hazards and must not be confused with perils. Illness, for example, is a peril creating loss of income and medical expenses, but it is also a hazard increasing the chance of loss by death.

Insurance companies recognize three types of hazard: *physical*, *moral*, and *morale*.

Physical hazard is an objective characteristic increasing the chance of loss from a given peril. For a simple example: coal mining and metal grinding are hazardous occupations because they increase the chance of illness by exposing workers to inhalation of mineral dusts.

Moral hazard is a subjective characteristic of the insured which increases the probability of loss. It is found in the insured's habits, financial practices, or lack of integrity. In life and health insurance, moral hazards are present in individuals of unsavory moral reputations, spendthrifts, alcoholics, dope addicts, and philanderers.⁶

Morale hazard, like moral hazard, is personal. Morale hazard arises out of indifference to loss. Possession of insurance may itself create a morale hazard. For instance, ownership of health insurance may result in a prolonged period of claimed disability since the incentive to get well may be reduced when insurance benefits are involved. Possession of hospitalization insurance has definitely been associated with an increased incidence of hospitalization.⁷ Life insurance, however, produces little incidence of morale hazard, for rarely does an individual become careless of life simply because he is insured.

A study of hazards is important to the understanding of insurance. Insurance companies must review the hazards involved when an application for insurance is submitted. If the hazards are unusually large, the company must either charge a higher premium, restrict the coverage, or deny the insurance.⁸

Loss. Loss is an unintentional decline in or disappearance of values arising from a contingency.

The major types of losses against which one insures through a life insurance contract are unexpected expenses and interruption of income. Death *can* bring about loss of future income; it *always* brings about expense.

For the typical family, loss of income resulting from the death or retirement of its breadwinner is the more serious; however, expenses of last illness and burial also can be a problem in those families operating on a close budget.

For the wealthy family, death taxes and the cost of probating the estate could well be the more serious loss. Loss of income, although large, might be of only secondary importance, especially in view of the high tax brackets to which that income was subject.

⁶ A problem relating to moral hazard in health insurance, not found in life insurance, is claim exaggeration. Cf. Chapter 11.

⁷ The hazard is not wholly subjective here. Hospitalization insurance frequently results in more people taking advantage of "hospital-needed" diagnoses.

⁸ Cf. Chapter 19.

Accident and sickness also involve both expenses and income losses. Medical, surgical, and hospital expenses can run into large sums of money. Disability resulting from accident or sickness can cause loss of income for lengthy periods, sometimes even permanently. The bulk of health insurance purchased today is for expense reimbursement. Most authorities, however, agree that income replacement insurance is the more important. If there is income, bills usually can be paid in time; however, if income stops, even though the medical and hospital bills are paid by expense-reimbursement coverages, nothing is available to pay the everyday living costs for the disabled person and his family unless he has income replacement insurance. Insurance companies are beginning to place more emphasis on the writing of disability income insurance.

Summary of Definitions. *Risk* is the uncertainty of financial loss. It must not be confused with *chance of loss*, which is the probable number of losses occurring from any given number of exposures. *Risk* must not be confused with *peril*, which is the cause of the loss. Still different is *hazard*, which is a condition that may increase the chance of loss. Finally, risk must not be confused with *loss* itself, which is the unintentional decline in or disappearance of values arising from a contingency.

2. METHODS OF HANDLING RISK.

Six methods are available for handling risk:

- (1) Risk may be avoided.
- (2) Risk may be assumed.
- (3) The hazard may be reduced.
- (4) The loss may be reduced.
- (5) Risk may be shifted.
- (6) Risk may be reduced by combining exposures.

Risk May Be Avoided. Some risks can be avoided. For example, a man with no dependents can avoid the risk of financial loss from premature death by remaining a bachelor. He can avoid the risk of loss of income resulting from disability or old age by marrying a rich widow who refuses to allow him to take a job for pay or profit. But risk avoidance is not always possible, and when it is, it is not always desirable. For example, it is possible to avoid the risk of loss of property by not acquiring any, but this does not seem to be a desirable method of handling this risk. So where risk avoidance is not the solution to the problem of handling risk, one or more of the other methods listed above will require attention.

Risk May Be Assumed. An individual may assume risk and bear the burden should a loss occur. Often it is good practice to assume risk. For example, both the frequency and the severity of accidental damage to railroad equipment could be reduced by prohibiting trains from operating above a speed of, say, twenty miles an hour. However, at that speed, rolling stock could make

fewer trips, thus yielding less income per invested dollar. Consequently, railroads elect to move at faster speeds. The gross return from any given piece of rolling stock is increased sufficiently thereby to offset the increased accidental damage.⁹

Although risk assumption is sometimes good business, frequently it is nothing more than the path of least resistance in meeting risk. Failure to take any action is automatic assumption of the risk.

Often when risk is assumed, there is an attempt to build a sinking fund to offset possible losses. Even with the use of sinking funds, risk assumption might prove unwise. Specifically, it requires time to accumulate a sinking fund large enough to meet heavy losses. If the loss is one which comes on slowly at a predictable rate—loss of income at retirement, for example—a sinking fund can be used effectively. The certainty of the date of the loss makes possible exact calculation of the rate of deposits needed. But if the loss is one the date or extent of which cannot be predicted in the individual case, then it is impossible to calculate the rate at which deposits to the sinking fund should be made. For example, a proposed \$30,000 sinking fund to offset the loss of income to a family occasioned by the death or disability of its breadwinner may stand at only \$5,000 when that death or disability occurs.

Failure to understand the limitations of sinking funds as a risk-bearing device is a common cause of economic distress. This does not mean, of course, that it is wrong to build a contingency fund to insulate against the effects of a loss which is both uncertain and uninsurable. Thus, a breadwinner who is uninsurable might find it desirable to build a contingency fund through stocks, bonds, or real estate in order to provide at least some financial protection for his family in case of his premature death or disability.¹⁰

The Hazard May Be Reduced. Measures may be taken to reduce the hazard; i.e., to reduce the chance of loss. For instance, the development of wonder drugs has materially reduced the hazard of premature death or prolonged disability from certain diseases such as pneumonia. The development of more effective treatment for the diseases of infancy has reduced the death rate during those years.

The Loss May Be Reduced. Risk may also be handled by reducing the loss when it occurs. In this case, the risk (uncertainty) of loss is neither eliminated nor reduced, but its severity is checked. For example, while periodic medical examinations may not lessen the risk of cardiovascular disturbance, they can often catch the trouble in its initial stages and so lessen the

⁹ Theoretically, railroads could increase speeds still more and thus further increase efficiency in the utilization of equipment, at the expense of a greater incidence of accidents. However, since not only property but also human lives are involved, there comes a point at which the accident ratio is socially unacceptable. Therefore, both statute law and railroad regulations set speed and safety standards.

¹⁰ The use of a contingency fund to handle risk must not be confused with self-insurance. Self-insurance is possible only where there is a large number of comparable exposures to the same peril so that a definite loss ratio can be predicted. It follows, therefore, that it is impossible to self-insure one or two exposures.

severity of the affliction. Further, findings of such examinations may suggest medical treatment that will also reduce the hazard.

Risk May Be Shifted. One method of shifting risk is *hedging*. Hedging is a transaction involving the making of commitments on both sides of a risk so that whatever happens, the commitments offset each other. The process is probably best illustrated by a betting transaction:

A "loyal" alumnus creates a financial risk for himself by betting \$25 that his alma mater will win Saturday's homecoming game. As the day of the game approaches, he begins to think his judgment of his team's chances was more subjective than objective—more a matter of emotion than a study of the team's season record. So he decides to shift the risk to someone else. He bets \$25 *against* his alma mater. Now, he can sit back and watch the game without worrying over his money because his commitments exactly offset each other. Whichever team wins, he will both win and lose \$25, coming out even.

In legitimate business, hedging is constantly practiced in connection with such transactions as the buying and selling of wheat and other grains.¹¹

Risk-shifting is not an uncommon practice in meeting the perils of premature death, disability, and old age. A man may refuse to buy life insurance and thus automatically shift the risk of loss resulting from his premature death to his widow and children, or other members of society (taxpayers or private charity). He may refuse to insure against old age and shift the risk of loss to his children. He may refuse to insure against disability and so shift the risk of this loss to relatives, friends, and charity. In the family society that characterizes our economy, most risks that are left uncovered by one member of the family are automatically shifted to other members—usually the more provident ones, sometimes merely the ones with least resistance.

Risk May Be Handled by Combination. A large employer has less mortality risk in providing pensions for his employees than does a small employer. As has been explained, the greater the number of exposure units, the less the percentage of probable deviation from the average expected loss and the more predictable (and hence budgetable) the cost of pensions. The small employer is able to secure the same advantage the large employer has by combining his employees with those of other employers in an insurance "pool" so that he achieves the same predictability of results as his large competitor.

3. INSURANCE AS A METHOD OF RISK-BEARING.

The meaning of "insurance" is often confused. It is sometimes used to designate a fund which is accumulated to meet uncertain losses. For example,

¹¹ There is a tendency to consider hedging as gambling and somewhat immoral—and the broker, through whom a hedging transaction is made and the "futures" buyer who makes the transaction possible, as elements somewhat deleterious in our economy. However, because of their essentiality to hedging, and because hedging shifts possible loss from a business it might seriously harm, the indication would seem to be that at least not all "speculation" is reprehensible but that some of it actually serves to stabilize our economic structure. Since the potential loss is created by competition, the speculation required to offset it can be eliminated only by eliminating that essential element of a free economy. competition.

a manufacturer of style goods adds to his prices early in the season to build up a fund to cover possible losses at the end of the season when he may have to reduce prices to clear his inventory.

A transfer of risk is sometimes spoken of as "insurance." An individual who contracts to indemnify another for an accidental loss is said to "insure" him.

However, not all preparations to handle uncertain losses are insurance, and to identify as insurance either an accumulation of a reserve or a transfer of risk is erroneous.

Definition of Insurance. An adequate definition of "insurance" must include both the building up of a fund or a transfer of risk *and* a combination of exposure units having the same common risk into an interrelated group.¹²

Insurance itself may be defined as a device for reducing risk by combining a sufficient number of exposure units to make their individual losses collectively predictable. The predicted loss is then shared proportionately by all those in the combination. This definition implies *both* that uncertainty is reduced and that losses are shared. These are the important aspects of insurance.

For the individual insured, insurance is simply a device that makes it possible for him to substitute a small but certain cost (the premium) for an uncertain but potentially large loss (the amount of the insurance) under an arrangement whereby the few who suffer loss are compensated by the many who escape loss.

The Law of Large Numbers. Insurance is based on mathematics; specifically, on that branch of higher mathematics known as the "Theory of Probabilities." In that branch of mathematics, insurance is concerned primarily with the "Law of Large Numbers" (or the "Law of Averages," as it is commonly called).

The Law of Large Numbers is based on the regularity of the occurrence of events. Therefore, what seems random occurrence in the individual happening, seems so only because of an insufficient or incomplete knowledge of what may be expected to occur. For all practical purposes, the law may be stated thus:

The greater the number of exposures, the more closely will the actual results obtained approach the probable results expected from an infinite number of exposures.

As an example: The underlying probability at infinity is that half of all coins tossed into the air will fall "heads," and half "tails." The greater the number of tosses, the nearer the actual results will approach the underlying probability.

To put it another way: Happenings that in the individual appearance

¹² One man with 1,000 buildings at different and widely scattered locations is in the same position from the standpoint of, say, fire insurance, as are 1,000 men with one building each similarly diversified. In the first case, we have a situation in which true self-insurance is possible, in the second, we have a situation in which only outside insurance will give adequate protection.

seem to be the result of pure chance occur with increasing regularity as the instances observed become more numerous. Driving a car, you turn a downtown corner and dent your fender against another car. To you, the event seems wholly unpredictable. Had you started from home a minute later, had you been delayed along the route a second more, had you pulled away from the last stop light less rapidly, there might have been no accident for you. It seems no formula could have predicted the accident.

Yet to the policeman on the corner where the accident took place, prediction is not nearly so impossible. He can tell you with a fair degree of accuracy just how many drivers will be involved in an accident at that corner this week. If you should ask him to give you the statistics on a monthly basis, he could tell you even more accurately; and should you ask him on the basis of a year, the accuracy of his prediction would lead you to believe he has "second sight."

The policeman's accuracy in predicting the number of accidents increases, not because of the varying bases of times for which you asked him to predict, but because the greater the elapsed time, the greater the number of drivers exposed to the peril at that corner, and *the greater the number of exposures to a peril, the nearer the results approach the underlying probability.*

Just so, an insurance company, with statistics on millions of exposures, can tell with reasonable accuracy the probable number of people who will be killed, maimed, and injured in automobile accidents between now and next Sunday. Such accuracy, as in the case of the policeman on the corner, seems uncanny unless it is held in mind that *as the number of exposures increases, the nearer will be the actual results to the underlying probability.*

Thus, the law of large numbers becomes the basis of insurance. Under the operation of this law, the impossibility of predicting a happening in an individual case gives way to demonstrable ability to do so when a successive number of exposures is considered. Applying these conclusions to life and health insurance, it is found, for example, that every year a certain number of accidents and illnesses can be predicted, and a certain number of deaths in each age group can be projected. Given a large group of exposures, prediction becomes, not guesswork, but mathematical calculation.

Loss prediction is limited, however, in three ways. Inasmuch as the number of exposures never reaches infinity, there will always be a deviation from the average; that is, losses will not correspond exactly to the average loss as indicated by statistical evidence. In the second place, the statistics on which predictions are made are subject to error. They are based on sampling techniques and do not always measure accurately what has taken place in the universe. Furthermore, successful loss prediction depends upon the ability to forecast trends, a feat which no one can accomplish with perfection. Improvements in mortality have been occurring at a rate which makes statistics based on past experience out of date unless these statistics are adjusted to reflect such improvements. Since these adjustments are to some extent guesswork,

insurance companies cannot predict losses exactly. Therefore, they cannot eliminate their risk completely but can only reduce it to manageable levels.

4. ESSENTIALS OF AN INSURABLE RISK.

Not all risks are insurable. Certain tests must be met. The requisites of insurability are, broadly:

- (1) There must be a large group of homogeneous exposure units.
- (2) The loss must be definite.
- (3) As far as the individual occurrence goes, the loss must be fortuitous and substantially beyond the control of the individual.
- (4) The potential loss must be large enough to cause economic hardship.
- (5) The cost of insuring must be economically feasible.
- (6) The chance of loss must be calculable.
- (7) The loss must not be likely to happen to the majority of the insured simultaneously.

A Large Group of Exposure Units. A large number of exposure units is necessary to make possible the functioning of the Law of Large Numbers. A life insurer, for instance, cannot operate on the basis of ten or twenty lives. The number of exposure units would be so small that the actual losses might greatly exceed the predicted losses. Insurance is not practical when the probable deviation from predictable losses is so large that premiums must be heavily loaded to take care of it. Losses must be predictable within a relatively narrow range.

The exposure units must be homogeneous, i.e., be relatively alike. An insurance company which insured a heterogeneous collection of persons in an unknown combination of ages, states of health, and dangers of occupation could not predict what death losses would result. Predictions are possible only with groups consisting of known combinations as to age, health, and occupation. Therefore, the insured must be classified according to these characteristics. The rate of losses among a group of persons all of whom are aged 22, in good health, and in nonhazardous occupations *can* be predicted; such a group is homogeneous. However, insurance classifications must be few enough in number so that there are a great many exposures in each of the classifications used. For example, age group classifications in life insurance are on the basis of full years rather than exact ages down to the month. They are also limited in the number of classifications for health and occupation. Thus, a category of retail sales managers, all with moderately good health and all 42 and $\frac{7}{12}$ years old, would be much too small to yield enough exposures to produce a reliably predictable loss ratio.

Definite Loss. The loss must be clearly observable and difficult to feign. Death is almost impossible to feign, at least in most civilized countries. Disability, on the other hand, is more easily counterfeited. Consequently, the moral hazard involved with each applicant must be even more carefully checked in health insurance than in life insurance.

A Fortuitous Loss. If there is certainty of loss, the peril is economically uninsurable. Depreciation, normal credit losses, and the like are not insurable. There is no uncertainty about their individual occurrence. They should be handled by sinking funds or treated as a regular cost factor in pricing. Only fortuitous loss is insurable.

Death itself is not an insurable peril, because everyone is sure to die. In life insurance, however, the insurance is not against the peril of death but against the peril of untimely death—death which interrupts economic life.

Accident, sickness, and old age (the length of life beyond the earning span) are uncertainties. Not everyone experiences the losses they occasion. Therefore, the frequency and duration of their occurrence are unexpected and hence insurable.¹³

Large Loss. The size of the potential loss must be large enough to represent a financial strain or economic hardship to the persons exposed to it. It costs money to operate an insurance company, and since net premiums must be "loaded" to cover the insured's share of this cost, the premiums for insuring small losses tend to be uneconomically high in relation to the amount of the exposure. For example, a life insurance policy with a face amount of \$25 could be written for one year, but the cost of writing and administering the contract would tend to price it out of the market. At age 50, the actuarial cost of the coverage would be about 20 cents because the chance of death during that year is 0.8 per cent.¹⁴ The cost of issuing the policy and handling the records could easily amount to \$4.00 (probably much more), bringing the total cost of the transaction to \$4.20. In effect, such a contract, if sold at cost, would require a gross premium of about 17 per cent to cover a 0.8 per cent chance of loss, not a very attractive arrangement. Better odds can be found at the race track. Such small losses, therefore, are better handled through budgeting procedures than by means of insurance.

On the other hand, the premium for a \$1,000 one-year policy issued at

¹³ On two qualifications (definiteness and accidental nature), disability comes near the borderline of uninsurability. Even such extremes as loss of limb or sight have occurred under circumstances which have at least given rise to doubt that they were accidental. And when is a man capable of earning and when not? Physical impairment can be observed and measured, there are also psychological states that can render a man disabled but which are difficult to measure. Assume you are a physician to whom a patient comes for certification of disability. The patient is unable to find employment; his family is literally starving; you know that unless he can obtain income from disability insurance, he will commit suicide in order to obtain funds for his family from his life insurance. Since a suicide drive is a psychopathic condition, can you say this man is *not* mentally unfit to earn a living and hence *not* disabled? From such situations arises the need for clear definitions of what should be considered disability for the purpose of the insurance and for restrictions and limitations on benefits that render disability financially unattractive while still protecting against economic catastrophe. Unfortunately, the result of these limitations and restrictions too often renders not only disability itself unattractive but also renders disability insurance unattractive in the eyes of some individuals who need what is in some ways this most important of personal insurance coverages.

¹⁴ This figure is based on the 1958 CSO Mortality Table.

age 50 is quoted in one rate book at \$14.44. This represents a premium of slightly over 1.4 per cent to cover a 0.8 per cent chance of loss, certainly not a bad proposition for a man who cannot afford the loss.

If the potential loss is large enough to cause severe economic stress, insurance against it is worth the cost even though the premium has to be loaded for expenses. The determination of what constitutes a potential loss large enough to be economically insurable depends on each individual's circumstances. A \$300 hospital bill might be ruinous to one man, and therefore a loss against which he should insure. For another, a hospital bill under \$3,000 might not be financially disturbing, and therefore would be uneconomical to insure.

The size of the potential loss from disability or premature death is far greater than most people realize. The loss equals the value of a man's earning capacity over the period of disability or between the time of his death and the end of a normal earning span. The hardship created when a man outlives his earning ability also can be severe. Therefore, the risks covered by life and health insurance meet this test of insurability.

Economically Feasible Cost. It is not economically sound to insure against perils which produce a high chance of loss. Even though all other factors about them permit the calculation of a safe rate, such a rate is usually economically impractical. A life insurance rate could be calculated for a man aged 98, but no one would be likely to pay it. The probability of death among a group of individuals aged 98 (on the 1958 CSO Mortality Table) is about 668 out of 1,000 alive at the beginning of the year. Disregarding interest calculations, the pure premium for \$1,000 one-year term insurance at age 98 would be \$668. When the cost of doing business is added to the actuarial cost, the total premium comes close to, or is even in excess of, the face amount of the insurance, an obviously uneconomic rate.

The chance of major income loss from premature death (at most ages) or from disability is small enough to make the premium for insuring against each of them economic.

Although the amount of old age indemnification potentially necessary for any individual is extremely large, the cost of protection is within reach of most people for three reasons: (1) The individual who starts his insurance early has a large number of years over which to prepare for old age; (2) some will never reach retirement age, and their contributions toward a retirement insurance fund can be shared by those who do; (3) of those who reach retirement age, some will not live very long, thereby releasing funds to finance those who enjoy a long period of retirement.¹⁵

The test of economic feasibility includes feasibility of the cost of rating

¹⁵ The constant increase in the average length of life is exerting an upward pressure on the cost of providing old age security, so that a point might be reached eventually where the cost of private insurance for old age would not be economically feasible at today's generally accepted retirement ages. Perhaps a new definition of "old age" is necessary—one that defines it in terms of significant inability to work. Cf. footnote No. 17.

and underwriting. For example, separating the good from the bad moral and morale hazard within certain occupations or social groups is so difficult that the whole group may be listed as uninsurable. This is especially true in health insurance. The cost of the investigation necessary to determine the good risks in a group can be prohibitive.

The Chance of Loss Must Be Calculable. For some types of risks, the probability may be determined by logic, as has been noted. Logic determines that the probability of a flipped coin coming down "tails" is 50-50. No experience is necessary to determine the probability. On the other hand, the probability of death at age 25 cannot be reasoned from logic. It can be determined only from past experience—a mortality table, for example, which is a report of the number of people dying out of a given number who are assumed to be living at the beginning of each year.

If the probability cannot be determined either by logic or from history, it is not mathematically calculable, and the peril is uninsurable.¹⁶ This is one of the reasons unemployment is not insurable commercially. The probability can neither be calculated by logic nor determined from past history since unemployment does not occur with predictable regularity. The chance of loss resulting from disability, however, is measurable when the peril is properly defined in the policy.¹⁷

Unlikelihood of Producing Loss to Majority Simultaneously. If loss is highly likely to occur to the majority of the exposure units simultaneously, then the peril is generally uninsurable. Insurance operates on the principle that the few who suffer loss will be compensated by the many who escape it. If the

¹⁶ The tests of a large number of homogeneous exposure units and measure of probability may seem to be violated by "insurance" on the fingers of a pianist, voice of an opera star, anatomy of a burlesque queen, and the like. Known as "special risk" or "specialty" insurance, this is not true insurance. It involves transfer of risk from the insured to the insurer but not combination to reduce the individual risk to the residual risk of the mass. Two factors can make such coverage economically practical: (1) *Overcharge of premium*, there being no competitive or comparative rates and there being a tendency for the insured to overestimate the chance of loss and hence be willing to pay an uneconomic premium. (2) *Mass underwriting*, used as a substitute for mass exposure. The potential loss is parceled among a number of insurers, each taking a fragment small enough for him to handle without economic distress should the peril materialize. The position of each individual insurer ("underwriter") becomes that of a speculator, since, like the speculator, he has calculated his chance of loss subjectively rather than from objective logic or statistics. Sometimes on a new exposure a company must rely largely on guesswork. In the marine insurance field, this is not at all uncommon. However, these transactions are not gambling, since, as we have seen, the risk in gambling is created by the transaction itself, whereas here it exists apart from the transaction and continues whether there is any transaction or not. The transaction is best called speculation, since speculators take on risks inherent in the economy.

¹⁷ Were old age to be indemnified on a basis of the time at which it kills economic life in each particular case (rather than at a specific date uniform for a mass of exposure units), then the underwriting problems would be similar to those met in underwriting disability: When can earning power be said to have ceased for a given individual? Men can be found who are capable of keeping up the pace of business at 80. Others are wholly unable to do so when 15 or 20 years younger.

many suffer the loss, then the few will be inadequate to compensate them—except at a premium that would violate the test of economic feasibility.

The chance of the perils of disability or death producing catastrophic losses is unlikely, assuming, of course, proper underwriting distribution. For protection against catastrophic exposures, life insurance companies, for example, insert war clauses in policies issued during war emergencies.

Although the above characteristics are considered requisites for insurability, they are not always adhered to by companies which write insurance contracts. To illustrate, in the life and health fields, some coverages are written for low amounts; others are written where a high chance of loss exists; and still others are written where a chance of loss is not predictable. Thus, surgical schedules covering amounts as low as \$10 are found; maternity benefits are written for young married women; and major medical insurance is written providing coverage for a high percentage of almost all medical expenses in excess of a deductible amount.

5. INSURABLE VALUE OF A LIFE.

The intrinsic value of the life of an individual results from his knowledge, ambition, perseverance, initiative, honesty, personality, and judgment. These qualities, being intangible and interacting, are difficult to appraise objectively. In common practice, therefore, the insurable value of a man's life can be expressed more objectively in terms of its relationship to those who depend on it for financial support or gain. It can be measured by one or a combination of the following factors:

- (1) His contribution to the support of all those economically dependent on him.
- (2) That portion of his income which goes to charitable contributions.
- (3) That portion of the profits from a business which result from the contributions of his skill, labor, or management.
- (4) That amount by which his estate will be decreased by death taxes and other costs of dying, and by the process of transfer to his heirs.
- (5) That portion of his income that goes for the support of himself (as a measure of his economic value in the event of economic death by reason of illness or old age).

Although the above factors are valid bases for determining a man's insurable value, rarely can a given individual afford to insure the total amount of the value determined by them. This point will be demonstrated in Chapter 16. Thus, in the vast majority of cases, it is impossible to think in terms of full indemnity when planning a life insurance program. Instead, it becomes necessary for the individual to determine how much he needs to purchase in order to give his dependents (or himself at retirement) a minimum income for the minimum period they need to maintain themselves without undue financial

distress. This amount is, of course, subject to the ability of the insured to pay premiums. Each man must determine for himself the maximum amount of premiums he can afford. The details of life insurance program planning are discussed in Chapters 15 and 16.

6. SUMMARY.

Necessary to an understanding of any phase of insurance is an understanding of the basic principles on which the operation of insurance rests. First, certain definitions are necessary: (1) *Risk* = uncertainty. (2) *Degree of risk* = the accuracy with which a given loss can be predicted. (3) *Chance of loss* = the probable number of times in any given number of exposures that loss will occur. (4) *Peril* = that which can cause loss. (5) *Hazard* = that which increases the chance of loss. (6) *Loss* = an unintentional decline in or disappearance of values arising from a contingency.

Risk may be handled in six ways: (1) It may be avoided; (2) it may be assumed; (3) the hazard may be reduced; (4) the loss may be reduced; (5) the risk may be shifted; and (6) the risk may be reduced by combination. This last method of reducing risk is by combining like exposures into a group large enough to make the loss predictable with reasonable accuracy. The loss is then shared proportionately by all members of the group. Risk reduction and loss-sharing are the foundations on which insurance rests.

To be a subject for insurance, the peril must threaten a large and homogeneous group; it must produce a loss that is definite in time and place and which is accidental (as opposed to expected). Furthermore, such a peril must be capable of producing a loss large enough to be economically disturbing to the individual it threatens; yet the cost of insuring must be economically practical. The chance of loss from the peril must be calculable, and the peril must not be likely to produce loss to the majority of insured persons simultaneously.

Economic death, whether occasioned by disability, death, or old age, is an insurable peril. The insurable value of a life is customarily determined by its value to those dependent on it for support or profit; however, because the value of a life to dependents is exceedingly great, the typical individual finds that he must set that value for his own case, not by the maximum potential, but by the minimum standard on which his family can get by without economic degradation—and on what he can get by in old age. What “economic degradation” may be in any given case is a matter for subjective determination by the individual insured.

QUESTIONS FOR CLASS DISCUSSION

1. Distinguish between chance of loss and degree of risk.
2. Reduction of hazard or loss may reduce degree of risk, or it may increase it. Explain. If reduction of hazard or loss increases degree of risk, is the net result desirable?

3. Is it possible for there to be greater risk when the chance of loss is $\frac{1}{10}$ than when it is $\frac{1}{5}$? Explain your answer.
4. Could the death of an idle playboy cause economic loss to his family?
5. What are ways of handling the risk of premature death? Old age? Disability? Which is the best method in each case?
6. Comment on the following statements (a) Insurance reduces but does not eliminate risk. (b) Risk makes insurance both desirable and possible.
7. Life insurance companies usually do not underwrite the risk of death in the armed forces in wartime. What test of insurability would they be violating if they did? Why can the government insure this risk?
8. Distinguish among insurance, gambling, and speculation
9. Is there more risk in the writing of life insurance or of disability insurance? Explain your answer.
10. What is the value of a human life for insurance purposes? Why must a life usually be insured at less than its full value?

CHAPTER 3

Term and Endowment Contracts

Functionally,¹ there are three basic types of life insurance policies: *term*, *endowment*, and *whole life*. In addition, there is the annuity contract, sometimes called "life insurance in reverse." The purpose of this chapter is to discuss the nature and uses of term and endowment contracts.

1. TERM INSURANCE.

Definition of Term Insurance. A term policy is a contract which offers financial protection against the occurrence of death within the given period of time stated in the policy. It offers no protection or values in case of survival beyond the specified period.

Term insurance is comparable to most forms of property insurance contracts. For instance, an automobile insurance policy offers financial protection against the perils named in it for a period of one year. It may be renewed for another year, but it then becomes a new contract. Fire insurance is often written for periods of one, three, or five years and expires without value. If the protection is to be continued, a new policy must be obtained or the old one must be renewed.

A policyholder who takes five-year term life insurance has protection against the financial consequences of death within that period but not beyond. If the policy is renewable, he may extend it for another term period at the

¹ Actuarially, when insurance is written to the limiting age of the mortality table (age 100 on the tables being used today), there is only one type of life insurance policy, because there is practically no distinction between a whole life policy, a term to age 100, or an endowment at age 100. If the net premiums and reserves for the three of them are calculated, it will be found that the differences dollar-wise are *de minimis*, and that a good case can be built up to indicate that there is a smooth transition from one to the other. While this is true for policies written to the limiting age on the mortality table, it is not true of policies written for shorter durations. Policies, for example, issued at age 25 for a twenty-year period may be either term, in which case the insurance is payable only on the death of the insured within the twenty years, or endowment, in which case the insurance is payable on the death of the insured in the event of his death prior to age 45 and fully payable to him if he is surviving at age 45. But based on usage and general understanding, it is convenient to classify policies into the three basic types described in this and the next chapter.

rate applying to the new age; or he may, if it is not renewable, take a new policy, provided he is still an acceptable risk.²

The principal appeal of term insurance is its low cost. For example, a man aged 25 can purchase a \$10,000 ten-year term policy for an annual gross premium of about \$80. The cheapest form of permanent insurance would require a gross annual premium of more than \$200.

A principal deterrent to the purchase of term insurance is its lack of cash values available for emergency or retirement income.³ Quite often an insurance buyer objects to the purchase of term insurance because he does not want to "pay all those premiums and get nothing back."⁴ In the above example, at the end of ten years, the ten-year term policy will expire without value, whereas the permanent policy will have a cash value of \$1,220.⁵ It should also be mentioned that some life insurance agents discourage the purchase of term even in cases where it should be sold, since term insurance yields them a lower commission. Most companies pay a lower rate of commission on term insurance, and in every case the premium on term is lower, thus yielding fewer commission dollars.

Uses of Term Insurance. Term insurance will serve the policyholder adequately only when the protection need will expire simultaneously with the expiration of the term period. For example, a young mechanic borrows \$10,000 to finance the purchase of machinery and tools to equip his shop. He feels certain that if he lives five years, he will be able to pay back the loan out of business profits. However, should he die before the end of that time, his family will have to bear the burden of the indebtedness. Therefore, his need is for a \$10,000 term insurance policy written for five years. If his death occurs while the loan is still outstanding, the proceeds of the insurance will extinguish the debt and his family will be left an unencumbered estate. Frequently, lenders will request, sometimes even require, that their borrowers purchase this type of life insurance protection.

² Some term policies, however, may be changed to a permanent form of life insurance without medical examination or other underwriting scrutiny, within a given time before the end of the term period. See discussion of convertible term insurance later in this chapter.

³ While the short term policy has no cash values, the long term policy is an exception. For example, in one company, a \$1,000 term to age 65 issued at age 40 will have \$7.39 in cash values in three years and \$61.56 in ten years. In the nineteenth year, the cash value will be \$78.66. After that, these values decrease. They will be \$73.30 in the twentieth year and will reach zero by the end of the twenty-fifth year. So in long term insurance, while there may be some small value, even this will disappear by the time retirement age is reached.

⁴ For some strange reason, he does not feel this way about his automobile insurance premiums. Perhaps it is due to the fact that automobile insurance is sold as protection only, whereas life insurance is sold most often as a vehicle for accumulating a savings fund.

⁵ All rates and values quoted in this chapter are based on participating policies unless otherwise noted. For simplicity of illustration, it is assumed that all dividends are taken in cash. Rates and values vary slightly among companies.

Other examples of life insurance needs for which term insurance can be used advantageously may be cited:

A father who depends on his current earning power to finance his son's education can insure this earning power for the duration of the college period.

A business engaged in research in which one man is absolutely vital can insure its investment in this research by insuring the life of the key man for the duration of the project.

A young businessman embarking on a new venture can insure his investment of time and money in the enterprise by insuring his life during the developmental stages of the business. It is usually several years before the new business will be of any value itself, apart from the owner.

A family man with a mortgage on his home may desire to insure his life for the decreasing amount of the mortgage for the period of its amortization so that in the event of his death he will be able to leave his family a home free of debt.

These are by no means all the situations in which term insurance may be used properly; however, they illustrate the point that term insurance is to be used wherever there will be a loss if the policyholder dies before the end of a specified period but where there will be no loss if he dies after that period.

Term insurance is also widely used by young people who have only a small amount of money to budget for insurance but who, on the other hand, have a large protection need. In such cases term is used, not because of a temporary need, but because of a temporary financial condition. In many cases the policyholder plans to convert the term into a permanent policy form—perhaps little by little—as he has more money available for premiums. For the same premium outlay, term will provide more adequate, although temporary, protection than will permanent policy forms.

Term insurance is attractive to students in professional fields, particularly those working toward one of the doctorates, and therefore having many years before they will be able to afford permanent insurance sufficient to cover their protection needs. In normal times, a young man starting out in a profession—medical, legal, or any type where his earnings depend upon building up a clientele—may have to get along for as many as ten or more years on an income too low to pay for adequate protection through permanent insurance. Such men will frequently obtain protection by using term insurance as an emergency device.

College students planning marriage and facing military service might find term insurance appropriate. They can obtain adequate protection in this way while postponing the purchase of permanent insurance until such time as they establish themselves permanently in civilian life.

Term insurance, if it is convertible,⁶ will protect the policyholder's insurability for the minimum cost since, at the low term rates, a large amount of

⁶ That is, if it may be changed to a permanent policy form without evidence of insurability.

insurance can be purchased for a small amount of money. This large amount of protection can be continued on a permanent basis later if the policyholder chooses to convert it, irrespective of changes in physical condition and occupational hazards.

Many established people need more death protection than they can afford to purchase on a permanent plan. They are people who are willing to sacrifice, in whole or in part, old age protection for themselves in order to obtain adequate premature death protection for their families. They look to term insurance in such cases, not because it fits their need, but because it fits their pocketbooks. Term insurance gives the most for the premium dollar in premature death benefits but offers no protection against superannuation, and no cash for emergency uses.

Limitations of Term Insurance. Every policy form has limitations. These limitations exist only when there is an attempt to use the policy to fulfill a need for which it is not designed. If term insurance is used where the situation calls for permanent insurance, it has certain clear-cut disadvantages. Frequently, modifications of straight term insurance are available which might to some extent offset these limitations. These modifications are discussed later. In the meantime the limitations of straight term insurance are describable as follows:

(1) The need for life insurance protection may extend beyond the period of the policy. The policyholder may be uninsurable at the expiration of the term period, and therefore unable to secure a new policy. For example, a five-year term policy taken to insure a research chemist during a major project will expire before the project is completed if the chemist hits a snag and requires more time than the original five-year estimate. If the chemist loses his insurability during this period, insurance protection will be denied those who have invested heavily in the project, assuming the term policy is neither renewable nor convertible.

(2) When term insurance is used for a permanent and continuing need, the premium will increase at each renewal date and may become prohibitive in later years.⁷ The table on the following page shows the increased rate required at each renewal period of a five-year term policy. For example, the rate at age 25 is \$8.13 per thousand. The lowest-premium, permanent policy (continuous-premium whole life) at that age and in the same company, is quoted at \$20.40—well over twice the rate of the five-year term policy. It is easy, therefore, to see how a young man aged 25 might be tempted to take term insurance instead of continuous-premium whole life to meet his insurance needs.

⁷ This is true unless the need decreases in size each year to the extent that the total premium can be kept reasonably low by reducing the face amount of the policy. If the amount of insurance needed decreases enough each year to offset the rising rate, the total premiums will not advance. For example, the \$81.30 premium charged for \$10,000 of five-year term at age 25 will purchase, roughly, only \$7,500 of five-year term at age 35. If the need has been reduced by one-fourth, then the premium can be kept level. However, few people own enough life insurance to feel justified in reducing their coverage as they advance in age except during those later years when the children are no longer dependent on parental support.

Assuming, however, that the portion of the insurable need which he is covering with term insurance is a permanent one continuing throughout his life, he will find that his term insurance at age 55 (which is, by the way, the last age at which this particular company will write five-year term) will cost him \$32.40 a thousand, or more than half again as much as the level premium he would still be paying had he bought continuous-premium whole life when he was age 25.

Should he reach 60, he would be unable to continue his term insurance in this company. Assuming again that his need is a continuing one, such as the need for a burial fund, he would find not only that term insurance would grow prohibitively expensive in the later years, but also that there would come a time when, despite the fact that he still needed protection, he would be unable to buy it. He might, of course, change to a permanent policy form at that age if he is insurable. In the company used here for illustration, he would have to make that change in his sixtieth year—the expiration date of the last five-year term policy available to him.⁸

The annual cost of continuous-premium whole life at age 60 would be \$76.12 per thousand, almost four times the level premium at age 25. It should be pointed out, however, that a man aged 60 might need less death protection than would a man aged 25.⁹ Therefore, it might be possible for him to purchase adequate death protection at that age on a permanent policy basis, without unduly increasing premium outlay, by sharply decreasing his insurance coverage.

Annual Rates at Five-Year Intervals Representative Five-Year Term, Par. Basis¹⁰

<i>Age</i>	<i>Rate per \$1,000</i>
25	\$ 8 13
30	9 23
35	10 91
40	13 47
45	17 36
50	20 03
55	32 40

⁸ The current trend is to allow term insurance to continue to age 65 or even longer, but the practice in the industry is for companies to set some upper age limit beyond which they will not renew term insurance contracts.

⁹ This would not be true if he had a large estate subject to heavy death and administration taxes. However, generally speaking, a man of 60 has only one dependent, his wife; and in all probability she will be at an age that requires less insurance for lifetime income than does a younger man's wife. For example, it takes more than \$71,000 insurance to provide a widow aged 40 a life income of \$250 a month, whereas at age 65 this income can be provided with less than \$42,000 of insurance.

¹⁰ "Par. basis" means participating basis, that is, an arrangement in which the policyholder participates in the "earnings" of the company through a policy dividend. Policy dividends are discussed in Chapters 10 and 23.

(3) An important use of life insurance is to provide income for old age. Term insurance, having no cash values at retirement cannot be used for this purpose. Some advocates of term contend that life insurance should be used only to protect against the economic consequences of premature death and that other forms of saving and investment should be used to create values for old age. Statistical illustrations can be constructed to show that other forms of investment will build more for old age than will savings tied in with life insurance. In answer, those who advocate life insurance as a savings medium point out that there is a big difference between statistical compilations and actual fact, and they contend that while it is possible to show larger gains from investments, such illustrations must assume more "if's" than do savings through life insurance. Specifically, their argument is based on five observations.

(a) The average person is unable to save over an extended period of years unless faced with some compulsion or penalty. A savings plan combined with life insurance compels a man to save at a time when he might skip a deposit under other plans. The company sends the policyholder a premium notice, the life insurance agent urges him to pay his premium, and the policyholder himself looks upon his life insurance premium payments as an expense and budgets for them accordingly. The penalty for not paying the premium is the lapsation of the policy—something which "goes against the grain" of the average person.

(b) Not only is there the inability on the part of the average person to save regularly each year, but also there is the difficulty of keeping that which is saved. It is relatively easy on a man's conscience to draw savings from a savings account or to liquidate a government bond or corporate security to raise money to buy a temporary luxury. People, however, are not so quick to cash in their life insurance policies. Many will not surrender their policies before retirement for anything short of an emergency.¹¹ The result is that the retirement fund is more nearly certain to be there at age 65 if it is tied up with life insurance.

(c) Savings placed in life insurance policies earn a fair rate of return. In order to earn more, one must invest in properties or securities which require not only investment skill to prevent loss, but also more time for management than the average person has available if he has regular employment. There is no assurance that even keen investment skill can prevent losses during adverse market conditions. Cash values in a life insurance contract are unaffected by market conditions.

¹¹ A theoretical advantage in buying term and investing the difference in other forms of investments lies in the fact that in an emergency, savings can be withdrawn or securities liquidated without lowering the amount of life insurance protection. However, such withdrawal reduces the total estate to the same extent as if a policy loan had been effected.

(d) Interest and dividend returns on general investments are subject to federal income taxes in the year earned, whereas, in general, the annual interest increments on life insurance policy values are not subject to the federal income tax until these values are paid to the policyholder during his lifetime. At this point, the taxable income is the excess of the amount collected under the policy over the total amount paid in premiums.¹² This tax treatment is an advantage to policyholders, because not only will their earned income drop upon retirement, but also their personal income tax exemption will be doubled at 65 and they may be given a retirement credit. Thus, if the policy values are paid out over the period of retirement, the amount subject to taxes in any one year will be small.¹³

(e) The low interest rates available on high-grade investments, suitable for retirement accounts, make it imperative for the typical person to liquidate his capital in order to have an income high enough to finance his retirement. For example, a man who is fortunate enough to accumulate \$30,000 by age 65 will be able to earn an investment income of only \$75 a month from this fund, assuming a 3 per cent return, net after taxes. This is hardly enough to provide for the cost of living even for a man content to sit at home in a rocking chair. The \$75 a month needs to be increased by supplementing it with a part of the principal every month. The principal must be used to purchase an annuity if an income is to be guaranteed as long as the annuitant lives.¹⁴ At age 65, \$30,000 will buy an annuity of \$189 a month.

If it is granted that liquidation of capital accumulations will be necessary for an adequate retirement income, there might be an advantage in making these accumulations through a life insurance contract. Currently, \$30,000 accumulated in cash values in a life insurance policy can be liquidated as an annuity for a male at age 65 under contract settlement provisions paying \$203 a month—\$14 more than could be purchased by a similar investment in a single-premium life annuity. In addition to paying more in annuity income, there may be another advantage of accumulating retirement funds through a life insurance policy. Annuity income rates are guaranteed in the life insurance contract. This might be an important guarantee, since mortality rates are decreasing. The effect of this decrease is a reduction in the amount of annuity income per thousand dollars of principal. These guarantees have proved valuable to those who purchased whole life insurance contracts over

¹² Actually, only part of the premium paid represents an investment of principal. The rest is pure life insurance expenses such as would be a premium on term insurance. Therefore, this formula, in effect, gives the policyholder a deduction for the premium paid for pure life insurance protection since the total premiums paid may be offset against the proceeds collected.

¹³ Cf. Chapter 17 for a more detailed discussion of the role of taxation in life insurance planning.

¹⁴ An annuity is a form of insurance contract under which the policyholder is paid an income, either for a stated period or for life. (See Chapter 5 for a more complete explanation.) Most general references to annuities or annuity income are, as here, to lifetime income rather than to a "period certain" income.

thirty years ago. Today, these policies can be cashed in at age 65 for annuity benefits that are much higher than could be purchased in annuity contracts with accumulated savings.

For example, a cash value of \$30,000 in one of these old policies could be liquidated as an annuity of \$236 a month—\$47 more than the \$30,000 would buy as a single-premium annuity at today's rates. This advantage, of course, assumes that the terminal fund will be \$30,000 regardless of the type of investment medium used, an assumption which, more than likely, will not hold true. Investment losses and withdrawals might reduce the accumulations in separate investments to a figure below the \$30,000. Conversely, speculative gains might increase the figure to more than \$30,000.

(4) Another disadvantage of term insurance for the average person is its lack of cash values (except in the longer term policies, as previously mentioned). This lack of cash values means that, should there come a time when the policyholder is unable to meet his premium payments because of financial difficulties, his protection will expire. There are no cash values out of which to obtain a premium loan. This is true also in the case of all forms of property insurance; however, it is rarely that these forms cannot be renewed in subsequent years when the money again becomes available, the only danger being the occurrence of a loss in an unprotected year. In contrast, the insurability of a policyholder may change overnight. He may find that when money again becomes available, it will be impossible for him to obtain insurance.

Types of Term Policies. Term insurance is written in a variety of ways, each designed to meet a particular type of need. These variations among term policies tend to offset some of the limitations of term insurance. For example, long term policies tend to offset the disadvantage of higher premiums as the age of the insured advances. Rates for long term policies at younger ages, however, call for considerably higher rates than do short term policies. At age 25, for example, term to age 65 is about \$14.44 a thousand as compared with \$7.66 a thousand for one-year term and \$20.40 a thousand for continuous-premium whole life insurance. Renewable and convertible term (to be explained later) may offset the disadvantage of expiring protection.

Briefly, term policies may be classified as follows:

Straight term policies are written for a specific number of years and automatically terminate at the end of the period. Most companies write five-year term, ten-year term, fifteen-year term, and twenty-year term on a level-premium basis.

Long term policies, written by many companies, are of three general types: (1) *Term-to-expectancy* policies are written for a term of years extending from the date of issuance to the end of the policyholder's life expectancy. For example, expectancy term taken at age 20 will, according to the 1958 CSO Mortality Table, expire in 50.37 years, or at approximately age 70. (2) *Life expectancy term* is the same as term to expectancy except that it gives

the insured an option to convert to a whole life plan, either for a drastically reduced amount of protection by continuing the premium payment at the expiration of the term period, or for the same amount of protection by paying an increased premium. Thus, for example, a man aged 20 who buys a \$10,000 life expectancy term policy for an annual premium of \$125 may, at age 70, continue to pay this same premium and convert to about \$1,200 of continuous-premium whole life insurance; or he may pay a premium of about \$1,000 and continue the full \$10,000 in force on a continuous-premium whole life basis. Of course, he could convert to an amount of insurance less than \$10,000 and pay the appropriate premium, or he could do nothing and allow his protection to terminate. (3) Under a *term-to-age-65* plan, insurance expires at age 65. There are variations of the plan. Some companies may write term insurance only to age 60, whereas others may write it to age 70.¹⁵

Renewable term policies are those which may be renewed at expiration for additional periods without evidence of insurability. However, the renewal premium will be charged at the rate for the attained age at the time of renewal. For example, a man 25 years old who takes out a \$10,000 five-year renewable term policy will pay an annual level premium of about \$81 for five years. Then, if he renews the contract at age 30, he must pay an annual level premium of \$91, which is the five-year term rate at that age.

Most of the principal companies write some form of renewable term insurance, although only a limited number will write *yearly* renewable term on an individual policy basis;¹⁶ i.e., term policies written for a period of one year and renewable at the end of each year up to an attained age, 60, for instance. More common are five-, ten-, fifteen-, or twenty-year renewable term. The period over which policies may be renewed is usually limited. Two common types of limitations are: (1) a limitation on the number of times renewals may be made, (2) a limitation on the age at which the insured may make his last renewal. Companies restrict the number of renewals in order to reduce adverse selection in later years. Policyholders in good health will be less likely to exercise their renewal privileges at advanced ages because of the higher rate, whereas those in poor health will be more inclined to continue their insurance in force as long as they are allowed to do so. The net result of

¹⁵ These three relatively common forms of long term policies are not always known by the name used above. For example, one company calls its life expectancy policy the "emancipator" policy, while calling its term-to-65 the "select economy" plan. One company even calls its term-to-expectancy policy a "life expectancy" policy. The terms as used in the above paragraph are adopted in this text because they are the most descriptive. Inquiry as to the exact provisions of any long term policy will reveal at once its classification. The trade name given to the policy rarely will indicate its true nature, however, most insurance jurisdictions require that the exact nature of the policy be stated somewhere on the face, usually in a footnote line at the bottom. The New York Insurance Department, in fact, places a great deal of importance on the use of policy names that are descriptive.

¹⁶ As contrasted to group insurance, for which cf. Chapter 13.

unlimited renewal could be a higher mortality rate among policyholders, and consequently an increase in cost.

Convertible term gives the insured the right to convert to any permanent or endowment form of insurance without evidence of insurability within a certain period of time before the expiration of the term of the contract. For example, a five-year term policy may be convertible any time before maturity or, in some cases, any time within the first three years; a ten-year term policy may be convertible any time before maturity, or, in some companies, any time within the first seven years. Term to 65 and expectancy term are usually convertible up to any time five years prior to their expiration date.

An example of a convertible term policy is the National Service Life Insurance plan of World War II. National Service life insurance policies were all written on a five-year term basis, with the privilege of conversion to a permanent plan at any time within five years, or within any longer period to which the privilege may be extended by the Veterans' Administration or Congress.

The convertible term plan is especially advantageous for a young man who is establishing a family but who is unable to afford the total premium required to give adequate protection under a permanent policy form. He can use a convertible term policy, which permits him to acquire a large amount of protection at a relatively small annual premium. Then, as his income increases, he can convert the term insurance to a permanent contract.¹⁷ For example, a young family man aged 23 can purchase \$20,000, fifteen-year convertible term for an annual premium of \$165. He can convert this policy into a continuous-premium whole life at age 35 by increasing the annual premium \$385, making a total premium of \$550. By then, not only should he be able to afford the additional premium, but also he might want to start building a cash value for retirement while he still has time to accumulate a fund of reasonable size.¹⁸

Automatic convertible term policies are those which are automatically converted into continuous-premium whole life or some other plan of permanent insurance at the end of a given number of years (usually one to five). They may also be converted earlier if the insured so elects. The automatic nature of

¹⁷ Convertible term policies contain a provision that they may, within a stated period of years prior to expiry, be converted into a permanent policy form without evidence of insurability either by (1) paying in an amount equal to what the reserve would now be on the permanent policy had it been taken as of the date the term policy was issued, or (2) dating the permanent policy as of the date of conversion. In the first case, the premium on the converted policy will be at the rate for the age at which the term was issued. In the second case, it will be at the rate for the attained age.

¹⁸ He might wish to make the conversions gradually over the period of the contract. For example, he can convert \$5,000 at age 25 by paying an additional premium of \$60. At age 30, by stepping up his premium \$75 he can convert another \$5,000. At age 35, he can convert the final \$10,000 by increasing his annual premium \$190. In this way, the increase in premiums is gradual, with total premiums stepping up as follows: \$165, \$225, \$300, and \$490.

the plan is psychologically attractive because it takes the decision to convert out of the hands of the often reluctant policyholder, and conversion is made for him by the company at a time agreed upon when the contract is issued.

Decreasing term is another common form of term insurance. Under this type of policy, the amount of insurance is reduced each year while the premium remains level throughout the period.

An important use of decreasing term is to provide protection against the death of the breadwinner during the child dependency period, especially when the budget available demands strict economy in the use of insurance premiums. For example, in one prominent company an annual premium of about \$120 gross at age 25 will buy \$31,500 of convertible decreasing term, decreasing \$15.00 a year for twenty years. Dividends will decrease the net annual premium after they start, usually at the end of the first or second year. The policy will provide a monthly income of \$158.75 for twenty years if the insured dies during its first year. Should he die in subsequent years, the policy could be arranged to pay as follows, thus guaranteeing a fixed minimum income during the twenty year child dependency period:

<i>Year of Death</i>	<i>Monthly Family Income</i>
4th	\$155 80 for 17 years
8th	152 45 for 13 years
12th	151 50 for 9 years
16th	157.40 for 5 years
20th	252 25 for 1 year

During the early years of the policy the premium for these benefits under the decreasing term form is less than under the yearly renewable term form. For example, to provide \$31,500 protection at age 25 under yearly renewable term would require an initial premium of about \$210. A renewal of \$30,000 at age 26 would require a premium of about \$200.

Decreasing term is written most often on a monthly decreasing basis and in combination with permanent policy forms under family income or mortgage protection plans. These special plans are discussed in Chapter 6.

Exclusive of group and credit life insurance, of which over 90 per cent is written on a term plan, about 17 per cent of all private life insurance in force in the United States is on a term basis.¹⁹

Statistics on term are interesting. Contrary to what one would expect, level term seems to be purchased largely by high-income and high-age groups, including executives, managers, proprietors, and professional workers.

2. ENDOWMENT INSURANCE.

The endowment policy offers insurance protection against death for a specified period of time. If the insured lives to the end of the endowment period, the policy pays the face amount, either in a lump sum or, if elected

¹⁹ Regular and decreasing term, ordinary and industrial, plus term in combination with permanent policy forms.

by the insured, in installments. If he dies prior to endowment date, the face amount is paid to his beneficiary. Thus a \$10,000, twenty-year endowment policy promises to pay \$10,000 in event of the insured's death before the expiration of the twentieth year, or \$10,000 to the insured himself, if he survives the period.

The endowment policy might be said to be a savings fund protected by term insurance; i.e., the policyholder decides that he wants to build up a certain fund of money at the end of a given number of years. In a sense, the insurance company establishes a savings fund for him to which he contributes regularly and on which interest is compounded annually. If he lives to the end of the term period, he will have accumulated the cash desired. However, the insurance company further agrees that if he dies prior to the end of that period and before the "savings fund" reaches the face value of the policy, it will complete the "savings fund" for him immediately out of the mortality fund and pass the full amount on to his beneficiaries at that time.

For example, suppose a man aged 25 wants to accumulate a fund sufficient to put his newly-born son through college twenty years from now. He figures that \$5,000 will be the basic minimum necessary for this purpose. He wants to be sure that this fund will be available whether he lives or dies. So he buys a twenty-year endowment insurance contract²⁰ for an annual premium of about \$220 non-par. or net after dividends. By the time the father reaches age 38, he will have accumulated in his policy a savings fund of \$2,165 (known in technical language as the cash surrender value). Should he die during the next year, this amount, coupled with \$2,835 in insurance benefits, would make up the \$5,000 then payable to his son for later use in college. At the end of the nineteenth year, the policy is worth about \$4,675. Death during the twentieth year, therefore, would draw only \$325 out of the mortality fund to make up the \$5,000. Should he survive to age 45, the policy will have a value of \$5,000, which is the full amount the father wants to accumulate for the education of his son. The policy becomes payable at that time, and there is no longer any death protection under it. During the twenty years, the endowment policy has provided a decreasing amount of insurance protection while the savings fund was gradually accumulated. The total deposits made amounted to \$4,400. Interest on these deposits was enough to pay for the cost of the decreasing term insurance and still leave a surplus of \$600.²¹

Uses of Endowment. Endowment insurance is used properly when need for protection against premature death has been fairly well filled and there is a specific need for a fixed amount of cash at a given time in the future. For example, an individual who needs to build a fund through annual saving to pay off a debt falling due at the end of ten, twenty, or any given number of

²⁰ Don't jump to the conclusion that this is the policy he should buy. Defer your judgment until you have read Chapter 7.

²¹ While this is a useful illustration to explain the concept of endowment insurance, it is not technically correct as actuaries view it.

years might find an endowment policy useful. A savings fund would be an excellent way to meet the debt, except that if the debtor dies before the fund equals the amount of the debt, his family will be faced with the problem of making up the difference at a time when the family probably needs every cent of its money.

The endowment policy also finds use as a vehicle for saving for those who are in a financial position to save but who would not adhere to a savings plan without the semicompulsive features offered through a life insurance contract. This use of the endowment policy assumes that death protection is not of major importance; however, if it is of no importance whatsoever, other methods of saving might prove more economical if the saver can save without compulsion.

Endowment is a vehicle for the accumulation of funds for a specific purpose. For example, an endowment can be used to build a dowry for a daughter or a capital fund to help a son get a start in business. These are, of course, "luxury" uses of life insurance and should be ignored, except by families whose death protection needs are adequately covered. Also, unless there are tax problems to be solved through life insurance, other methods of building these special funds might prove more economical. They can be built without the expense of unneeded death protection.

Perhaps the most important use of endowments is to provide retirement income. Endowments at ages 60 and 65 are primarily intended to provide funds for old age. Purchased at relatively early ages, they offer a reasonably large amount of death protection per premium dollar, while accumulating a retirement fund that may be taken as cash or as an annuity income at those ages. For instance:

In one rate book, the participating premium rate per \$1,000 of endowment at 65 issued at age 25 is \$25.10. The rate for continuous-premium whole life in this same company and at that same age is \$20.76. At age 65 the cash values of the whole life policy will provide a retirement income of about \$4 monthly for life, per thousand of face value; while the endowment at age 65 contract will provide about \$6.75. Approximately \$125 a year invested in an endowment at 65 contract will provide \$5,000 of protection for dependents to age 65 and \$33.75 a month retirement income for the insured after 65 (male). The same amount of money will pay for about \$6,000 continuous-premium whole life, the cash values from which will provide the insured at 65 about \$24 per month income at 65.²²

A special form of the endowment policy is retirement income insurance, also called "special retirement endowment," "guaranteed life income," "income endowment," and many other names. The contract usually provides \$10

²² These retirement income figures are based on those quoted for male lives. The corresponding retirement figures for female lives are \$29 for the endowment and about \$21 for the continuous-premium whole life policy. Women receive less life income per given amount of insurance since, on the average, they live longer than men.

a month retirement income per \$1,000 of face value. Since under the life income option of one company writing the contract, \$1,000 provides only \$6.75 a month for a male at 65, it is obvious that the policy must provide for values at age 65 in excess of the face of the contract in order to pay \$10 per month per thousand of face value. In this particular rate book, the maturity value of the contract is \$1,623 per thousand at 65. The premium, consequently, is much higher than endowment at 65, being \$33.19 at age 25, almost \$8 per \$1,000 more. For female insured persons, the same policy pays only \$9.41 per thousand of face value at 65.²³ If the policy becomes a claim prior to retirement age, the face value or the cash value, whichever is the greater at that point, is paid. For example, if the man in the above illustration dies at age 55, his beneficiary will collect the cash value of the policy rather than its face because by that time the cash value will exceed the face value by \$36. If the insured dies at age 60, his estate will collect \$1,312. On the other hand, if he dies at age 45, his estate will collect the \$1,000 face value, for at that age the cash value of the policy is only \$595.

Limitations of Endowments. The limitations of the endowment form rise from its incorrect use. The temptation of receiving a large sum of cash at the end of a relatively short period of time leads many people to purchase the plan when their real need is for premature death protection. Many individuals have reached the endowment age to find themselves in possession of several thousand dollars in cash, an amount wholly inadequate to offset their continuing death protection need.²⁴ Technically, the limitations of the endowment are two: *expiring protection* and *low protection value*. Only when there is a limited and expiring premature death protection need plus a valid need for a specific cash fund at a given future date does the endowment policy find its proper application.

Endowment policies often appeal to people as a way to "win—live or die." This concept ignores the fact that insurance is not a wager. In insurance, as in other businesses, one never receives more than he pays for. In fact, with the endowment policy one is just as certain to lose as he is to win. An endowment policy is (speaking practically and not actuarially) made up of two types of insurance policies: term and pure endowment.²⁵ When a man dies, he "wins" on the term portion. When he lives, he "wins" on the endowment

²³ Some companies adjust the difference between men and women by having separate premium rates in order to provide \$10 per \$1,000 for either sex. In the example quoted above, a \$1,000 retirement income policy at age 65 for a female issued at age 25 would cost \$36.13 annually or about \$3 more than for males. A very few companies make no difference either in retirement payments or in premium rates on account of sex.

²⁴ The policy, however, may include other than cash options, for instance, the insured may accept a paid-up policy at an *increased* amount in lieu of cash payment. The option also may allow the insured to accept a paid-up policy of the original face value plus a refund of the difference between the cash value of the new policy and the face value of the endowment. Normally, either option will require that the policyholder be insurable.

²⁵ "Pure endowment" pays nothing if one dies before reaching the end of the endowment period but pays the face amount if he does live to the end.

portion. Whichever happens, however, he has paid not only for the portion that has matured as a claim, but also for the portion of the policy on which no claim has matured: the term, if he lives; the pure endowment, if he dies. If he dies, he would have been better off with pure term insurance. If he lives, he would have been better off with a savings account—or pure endowment, if available. However, because no one can know whether he will live or die within a stated period, he must prepare for whatever financial contingencies seem important to him and his family: death, survival, or both—and he must do this within his budget, putting first things first.

Endowment is not as popular as term. Exclusive of group and credit life insurance, about 10 per cent of all life insurance in force in the United States is written on the endowment plan. Contrary to what might be expected, endowment policies seem to be purchased largely by low income groups and groups under age 30.

3. SUMMARY.

Two types of life insurance contracts protect against premature death for specified periods only: term and endowment. Term differs from endowment in that it pays no benefits to policyholders who live to the end of the term period. Endowments pay a survivor benefit.

Term insurance is subject to much abuse and criticism by those who fail to see its sound uses. The line of attack on term usually is that (1) it might expire before the need for insurance expires, (2) rates become prohibitive in later years, and (3) no cash values are accumulated for retirement. These attacks ignore the possible modifications of straight term insurance. Renewable and convertible term makes it possible for a young family man to purchase adequate protection when his need is greatest and his ability to pay is lowest. At a later date, the term may be converted into whole life on a level premium basis and insurance protection is then guaranteed as long as it is needed.²⁸ Cash values, which may be used for retirement or emergencies, will then be accumulating.

Term insurance may well be used to cover temporary needs for insurance protection. It might also be used by low income families unable to afford anything else. Finally, it can be used by those who, for one reason or another, prefer to accumulate their savings outside of their life insurance.

People who prescribe term insurance for every need and who sharply criticize all forms of permanent life insurance are called "termites" by people in the life insurance business. "Termites" are to be condemned just as much as those who blindly criticize term insurance and refuse to see any of its values.

As stated, endowment insurance is less popular than term and perhaps

²⁸ The danger in this practice is that the higher rate at the conversion date might bring on lapse of the coverage or that the higher rate of the permanent form to which conversion must be made will result in the same thing.

less useful in the majority of cases in which it is actually employed. Endowment forms provide a low amount of death protection per premium dollar. They are best used, therefore, where death protection needs are low in relation to a need for a specified sum of money at a fixed future date.

QUESTIONS FOR CLASS DISCUSSION

1. Several unkind statements often are made about term insurance. Some are true, whereas others are off base. State and evaluate the arguments against term insurance
2. What are the various types of term insurance that offset the limitations of straight term?
3. Are there any limitations of straight term which cannot be offset by some other form of term?
4. Explain why long term policies have cash values whereas short term policies have no cash values.
5. Comment on the following statement: A man who owns a large amount of term insurance and is saving money regularly elsewhere should convert some of his term policies to whole life or endowment insurance.
6. The endowment insurance policy is the ideal insurance contract because you cannot lose with one. The policy pays off whether you live or die. It is the sure way of beating the company. Comment.
7. Describe a family situation which might call for the use of term insurance; of endowment insurance.
8. Often the advice, "Buy term and invest the difference," is heard. What is this *difference* referred to in the advice?
9. What do you think about the advice referred to in the above question?
10. Although, at any given age, \$10,000 of twenty-year endowment insurance costs more than \$10,000 of twenty-year term insurance, it gives less life insurance protection. Is this statement true or false? Explain.

CHAPTER 4

The Whole Life Contract

An unfortunate confusion in nomenclature exists in the use of the words "whole life." Sometimes the term is used interchangeably with "ordinary life." "Ordinary" has two very different connotations. It is applied to that class of insurance written for a minimum of \$1,000 on an annual premium basis.¹ The word "ordinary" is used to distinguish this type of insurance from industrial insurance—a form of weekly-premium insurance usually of less than \$1,000.² In an entirely different connotation, "ordinary life" is used to indicate that type of policy in which protection is furnished for the whole of life and upon which premiums are payable continuously throughout the lifetime of the insured. It is in its latter connotation that "ordinary life" is used interchangeably with "whole life."

Whole life insurance is a broader term than ordinary life. It is insurance that furnishes protection for the whole of life regardless of how many years premiums are to be paid. Premiums may be paid over a limited period, such as twenty or thirty years, or they may be paid in one lump sum at the inception of the policy. When premiums are to be continuous throughout the lifetime of the insured, the policy is most commonly referred to as an "ordinary life" policy. In this sense, "ordinary life" is simply a type of whole life insurance and is not to be used to include all whole life forms. A more descriptive term for such a policy is "continuous-premium whole life," as contrasted to "limited-payment whole life" and "single-premium whole life."

Uses of Whole Life. Of the several policy forms, whole life is perhaps the most adaptable to typical life insurance needs. Although some protection needs diminish as the individual grows older, no one ever outlives all need for protection against the financial loss occasioned by death. Death itself creates expenses, usually rather heavy. Consequently, there is always a need for life insurance protection regardless of the age of the individual.

The whole life policy is further versatile in that it contains a savings

¹ There has been a tendency in recent years to raise the minimum amount of ordinary policies above the traditional \$1,000. Also, almost all companies will accept semi-annual, quarterly, or even monthly premiums on ordinary; however, usually there is a "handling charge" when premium-payment frequency is more often than annual—although not always.

² Cf. Chapter 12.

element, the cash value, which permits the individual to protect simultaneously against the twin perils of premature death and of loss of income through old age. A whole life policy taken at a reasonably early age will have, at age 65, a substantial cash value per \$1,000 of insurance. Most companies will permit the insured to withdraw this cash value in the form of periodic payments, if he so desires.³ Some companies grant this income option in the policy. Others permit it by company practice.⁴ A whole life policy, therefore, makes it possible for the insured to obtain a relatively high amount of protection against premature death per dollar of premium during his "family years" when he needs this type of protection most, and yet, automatically and at the same time, provide for his old age. Moreover, he will have a yearly increasing emergency fund on which he can draw for cash or a loan if necessary.⁵

Limitations of Whole Life. For the typical person, the limitations of the whole life policy are few. It does not offer exact protection for every need, yet it is the one policy that will provide reasonably satisfactory coverage for almost every need. In other words, whereas a term or an endowment policy might fit certain specialized needs of the insured better at any given moment, whole life insurance also will take care of that same need reasonably well while simultaneously offering greater flexibility. If a need that originally called for term or endowment insurance is altered, such policies may no longer fit into the changed situation, whereas the whole life policy almost always will continue to serve the new needs reasonably well. It is the most flexible of all policies.

Perhaps the principal limitation of whole life insurance, when compared with term insurance, is its higher annual premium. The primary insurance need for most families is income for the wife and children in the event of the premature death of the breadwinner. If only a small amount of money can be budgeted by the family for life insurance premiums, the purchase of whole life insurance would mean sacrificing some needed death protection in order to build up cash values for emergency or retirement.⁶

Although the preceding paragraphs discuss the uses and limitations of whole life insurance, they do so only broadly. It is more realistic to discuss the uses and limitations of the various *types* of whole life policies, for their differences are significant. So, in the following discussion of the nature of each type of whole life insurance, consideration is given to its uses and limitations.

³ Cf. Chapter 5 for a discussion of annuities.

⁴ It should be held in mind that a contractual provision is a safer guarantee than "company practice."

⁵ Remember, of course, that this latter advantage might well be a disadvantage, for in order to obtain the use of this emergency fund, the insured must either surrender his insurance or encumber it (although perhaps only temporarily) with a loan.

⁶ The authors hasten to disavow that such a statement indicates they are "termites." The term advocate insists that term is the only useful policy form. The authors seek to show only that term has its uses and that it has advantages in proper application. Their endeavor is to show both proper and improper application of *all* policy forms.

1. TYPES OF WHOLE LIFE POLICIES.

Whole life policies are classified according to the period over which premiums are paid. The more common among them are the continuous, limited, and single premium plans.

Continuous-Premium Whole Life Policies. Continuous premium or "straight life" are contracts which provide death protection for the whole of life, with premiums payable continuously until death.⁷ The insured pays the premiums at each due date as long as he lives; when he dies, the proceeds go to his beneficiaries. In ordinary (as contrasted to industrial), payment of the premium may be made on an annual, semi-annual, or quarterly basis. A growing number of companies will now permit monthly payment of ordinary insurance premiums, since monthly payment for nearly everything a man buys is fast becoming the vogue. Payment at intervals other than annual usually increases the premium slightly. For instance, the semi-annual premium in one company is determined by multiplying the annual premium by 0.52. (The quarterly factor is 0.265 and the monthly factor, 0.092.)

Three reasons account for the higher fractional premiums: (1) If the full annual premium is not available at the beginning of the premium year, the company will earn less interest. The policyholder must make up this loss. (2) Also, and far more important, he must make up the extra expense involved in handling the premium more than once during the year—the mail room and bookkeeping costs, for example. Added together in the aggregate of thousands of premium payments, these extra expenses amount to a substantial total. (3) Many companies do not call for the unpaid portion of the annual premium should a policyholder die after paying, say, only a semi-annual premium. The loss of the other semi-annual premium also must be considered in setting fractional premium rates. This latter reason does not apply to those companies which refund the unearned portion of the annual premium at death. For example, if death occurs one month after the annual premium is paid, the death claim is increased by some companies by $1\frac{1}{12}$ of the annual premium.

Use of the Continuous-Premium Whole Life Policy. The continuous-premium whole life policy furnishes the maximum amount of *permanent* death protection at the lowest annual premium. For instance, at age 25, a gross premium of \$20.40 will purchase \$1,000 continuous-premium whole life insurance on a participating basis; at the same age and in the same company, that amount of money will purchase only \$911 of whole life paid up at age 65; and only approximately \$628 of twenty-payment whole life. The continuous-premium whole life policy combines insurance and savings with a minimum sacrifice of protection, since the investment feature of the policy,

⁷ Or until age 100 (age 96 on the older policies issued on the American Experience Mortality Table) when the policy automatically matures as a claim.

while present, takes less of the premium dollar than in the case of any other permanent policy form.

Limitations of the Continuous-Premium Whole Life Policy. The limitations of the continuous-premium whole life policy forms are few indeed. A common objection to these forms is that cash values available at age 65 for retirement income seem low when compared to those available in the endowment at 65 or with whole life paid up at 65. However, this is not a valid objection. To illustrate:

Early in life, every individual faces a twin peril, the peril of premature death and the peril of the destruction of earning power brought about by old age.⁸ He has no way of knowing which of these perils may occur. The continuous-premium whole life policy gives him the fullest protection possible in one policy against both of them. If he lives past the period requiring large amounts of premature death protection, the indemnity offered by the continuous-premium whole life policy against old age is not as satisfactory as that afforded by a policy designed particularly for retirement. However, if he dies during the critical family years, the indemnity payable to his family will be far more satisfactory than it would have been under a policy designed principally for retirement. For example, with a \$500 annual premium a man aged 35 can purchase about \$20,000 continuous-premium whole life, whereas he can buy only slightly more than \$14,000 endowment at age 65. The cash value at age 65 of the \$20,000 continuous-premium whole life will be just under \$11,000. The value at age 65 of the endowment, of course, is its face value of \$14,000. Therefore, when in this case a policyholder selects a continuous-premium whole life instead of an endowment at 65, he is getting approximately \$6,000 more in premature death protection and giving up approximately \$3,000 of old age protection—a fair and unselfish trade if premature death protection for his family is inadequate.

Another objection to the continuous-premium whole life policy is that premiums must be paid throughout life. Many people like the idea of a termination date on premium payments, especially since in late years they may find it difficult to pay premiums without undue hardship. This objection overlooks the fact that after the early policy years, the payment of premiums may be discontinued at any time without forfeiting the cash values which have been accumulated under the policy. If for any reason the insured can no longer pay premiums, he may, if he still needs the insurance, take either the paid-up value in the policy or its extended term value. In either event, he may discontinue the payment of premiums while continuing in force all or part of his premature death protection. If, for example, an insured who owns a continuous-premium whole life policy taken at age 35 were to find at age 65 that he no longer could pay the premium, he could exercise his right to take

⁸ Actually, he faces three perils, the third being the peril of disability. Cf. Chapter 11, "Health Insurance."

the paid-up insurance values in the policy. In an illustrative policy this would amount to \$705 per thousand of insurance in force. In other words, he could discontinue all premium payments on, say, a \$10,000 policy, and still have life insurance protection in the amount of \$7,050 for the rest of his life. If he needed more protection than \$7,050, and were not in particularly good health, he might decide to take the extended term option, which, without payment of premiums, would keep his policy in force at its full amount (\$10,000) for approximately fourteen years. Of course at the expiration of the fourteen years, when he would be 79, there would be no insurance.

Actually, limitations of the continuous-premium whole life policy become apparent only when the contract is used to fill a need for which it is not designed. For instance, if it is applied to a temporary need for protection, it does not give as much face amount per premium dollar as does one of the term insurance forms. Limitations also will appear when the continuous-premium whole life policy is used to cover what is more of a retirement than premature death protection need. However, for the typical individual, whose need is primarily for protection for his family in case of his premature death and only secondarily for protection against old age, the continuous-premium whole life policy is almost ideal. In most cases it provides a nice balance between premature death protection and cash value for retirement or emergencies.

Continuous-premium whole life is the most popular single type of policy. Exclusive of group and credit life insurance, about 30 per cent of all life insurance in force is on this plan.

Limited-Payment Life Policies. Limited-payment policies are those on which the premiums are payable for a stated period: ten years, twenty years, thirty years, or until the insured reached a given age, 60 or 65, for example. Several companies, instead of issuing a continuous-premium whole life policy, issue a policy paid up at age 85 or some similar advanced age. These advanced-age, paid-up plans, for all practical purposes, are continuous-premium plans, and should be viewed as such by the buyer.⁹

Under the limited-payment plans, the insured pays a level annual premium during the premium-paying years. With the payment of the last premium, the policy is "paid up" in the sense that no more premiums are required from the insured despite the fact that the full face amount of the policy will remain in force for the rest of his life. This means that the values are large enough so that in each of the remaining years the interest earned on them plus the survivorship benefits accruing (explained in Chapter 1) are sufficient to enable the company to accomplish two things: (1) to pay the

⁹ Advanced-age, paid-up plans or endowments (some companies write endowments at age 90) are written by some companies to offer higher cash and loan values than are customary with the traditional continuous-premium whole life plan. The higher premiums and thus higher cash values reduce the amount-at-risk at a faster pace, thereby making the plan more attractive to the company from an underwriting point of view.

cost of insurance and (2) to continue to increase the values in accordance with actuarial principles.

The high premiums of the limited-payment policy create values in the policy which by the end of the premium-paying period are sufficient to carry it to maturity. The policyholder of course could, at any time, surrender his contract and have these values paid to him in cash, invest the funds himself, and pocket the interest.

The limited-payment policy must not be confused with an endowment policy. With the payment of the last premium, a limited-payment policy is fully *paid up*, but it is not *matured*. A matured policy is one under which the face amount is paid either by reason of death or by reason of the survival of the insured to the end of a given period. A paid-up policy does not mature when it is paid up. The insured simply is relieved from the direct payment of any more premiums.

As has already been illustrated, the limited-payment life policy offers less protection for the same premium dollar than does the continuous-premium form. The reason for this is obvious: roughly, the shorter the premium-payment period, the larger must be each premium.¹⁰

Uses of the Limited-Payment Whole Life Policy. Often it is suggested that limited-payment whole life policies are properly used in a life situation in which the most productive years are limited to a relatively short span of time. A baseball player, for instance, knows that his earning period as far as his profession goes will be limited to ten or fifteen years. Therefore, it is argued, he may properly buy a ten-pay or fifteen-pay policy in order to adjust his premium payments to the most productive period of his life. For example, suppose a 21-year-old baseball player estimates he has fifteen years of professional life ahead of him. He decides he can budget \$1,000 a year for life insurance to protect against loss of this earning power by death. He reasons that it would be wise to have the policy fully paid at the end of his productive years; so he buys \$27,000 of fifteen-pay life. When he reaches age 36, the policy is paid up. But suppose that when he retires from baseball, he finds a high-paying job. He might be just as capable now of paying \$1,000 a year for insurance as he has been over the past fifteen years. But if he is uninsurable, he will be unable to purchase another policy.

Suppose, on the other hand, he had put this \$1,000 a year into a continuous-premium whole life policy. He could have purchased about \$58,000 of insurance, more than twice as much as under the fifteen-pay plan. If circumstances are such that he cannot continue his premium payments at age 36, he can take a paid-up policy of about \$23,000, only \$4,000 less than the amount of insurance available under the fifteen-pay life plan with the same

¹⁰ The participating rate in a representative company for twenty-pay life at age 25 is \$32.44 and for ten-pay life, \$54.42. Interest and mortality factors are important in distributing the premium among any given number of years, otherwise the cost of ten-pay would be exactly twice the cost of twenty-pay. See Chapter 20 for a technical and more accurate explanation of this point.

premium. If he can continue the premium, he may keep the full \$58,000 in force as long as he wishes. The continuous-premium whole life is, therefore, more flexible. Just as important as its flexibility is the fact that it offers \$31,000 more death protection during the crucial fifteen-year period when the family is growing up, which is more than worth the possible sacrifice of \$4,000 after that period expires.

If, on the other hand, this baseball player is among the fortunate few who are earning high salaries, he will be able to put more than \$1,000 into life insurance. Suppose, then, he can channel \$5,000 a year into premiums. Under the fifteen-pay life plan, this \$5,000 would purchase \$135,000 of life insurance—an amount which he considers adequate to settle his estate and protect his family. In this case, the fifteen-pay would be an attractive policy, for it would build up large cash values. The interest earned each year during this period of accumulation will not be taxable, resulting in an effective yield equivalent to (or better than, depending on the tax brackets of the insured) that on speculative investments. If at age 36 he continues to earn a high salary and is insurable, he can purchase more insurance on a high-premium plan. If he is not insurable, the present paid-up policy for \$135,000 should be adequate if he has done a competent job of estate planning.

The individual who plans to retire at age 65 and has arranged reasonable protection for his family in case of his premature death may properly use a limited-payment policy to provide the necessary cash to pay the cost of funeral and death taxes. As a result, he will not be burdened with the obligation to pay premiums out of his retirement income.¹¹

The limited-payment life policy sometimes can be used in special situations. For example, a father or grandfather who wishes to make a gift of paid-up life insurance to his child or grandchild may purchase the insurance on a limited-payment form so as to complete the payments before the policy is turned over to the child or grandchild. Limited-pay will often prove useful also in estate planning where income tax considerations are involved. Discussion of this latter point is deferred to Chapter 17.

The limited-payment life policy also is useful for the person who wishes to accumulate more cash value per \$1,000 of death benefit than is available under continuous-premium whole life, but whose investable funds are insufficient to buy endowment with its even higher cash accumulations. Like the endowment at age 65, a whole life policy paid up at age 65 is also a popular investment type contract. Table 6 shows the difference in the amount of cash value accumulated in continuous-premium, limited-premium, and endowment forms.

Limitations of the Limited-Payment Whole Life Policy. The larger investment element in limited-pay forms and the anticipation of completing

¹¹ Remember, too, that premiums on the continuous-premium whole life policy may be discontinued at age 65—at the expense of a reduced amount of insurance, of course.

TABLE 6.

**Comparison of Rates and Values of Continuous Pay,
Limited Pay, and Endowment**

(Issue Age 25, Non-Par Rates)

<i>Policy Form</i>	<i>Premium Rate Per \$1,000</i>	<i>Cash Values Per \$1,000</i>		
		<i>End of 10th Year</i>	<i>End of 20th Year</i>	<i>At Age 65</i>
Continuous-premium whole life	\$15 73	\$109	\$265	\$597
Life paid-up 65	17 43	127	308	754
20-pay life	27 28	229	552	754
20-year endowment	46 24	417	1,000	—

premium payments at some time in the future often lead to a misuse of these forms. If a man's need is primarily for protection for his family in case of his premature death—which is the basic need of most men—then the savings or investment factor should be a secondary consideration.

It must also be remembered that although the cash value for each \$1,000 under a continuous-premium form is lower, it is possible to buy more units of protection with a given premium than is the case with the limited-pay or endowment form. Thus, with a given premium budget the difference in the total cash value that a policyholder has available at any given time will be less than the per \$1,000 differences shown in the above table. In truth, in the continuous-premium whole life policy, the total cash value available at the end of twenty years, assuming the same amount of premium is spent in each case, would not be too far below that obtained under a twenty-pay plan. For instance, the cash value per \$1,000 at the end of twenty years according to Table 1 is about 2.1 times higher for twenty-pay life than for continuous-premium whole life. Actually, however, per dollar of premium paid, the cash value of the twenty-pay plan is only 1.2 times higher.

Nevertheless, the difference per \$1,000 might tempt the buyer to take the twenty-pay life when his premature death needs indicate he should take the continuous-premium. However, if he has \$500 a year to spend for life insurance, he can buy approximately \$31,800 of continuous-premium but only approximately \$18,300 of twenty-pay life. This means that if he dies before his family is grown, his dependents will receive \$13,500 less under twenty-pay than under continuous-premium, a deficiency which might prove disastrous for them. For instance, \$31,800 will provide a \$200 a month income for approximately sixteen years, whereas \$18,300 will provide this income for only about eight and one-half years. Income for this extra seven and one-half years might well mean the difference between a child's finishing school and having to quit school and go to work without adequate education and training.

A significant factor in addition is that the continuous-premium whole life will provide higher retirement benefits at age 65. The reason, of course,

is that premiums on the \$18,300 twenty-pay life will be paid until age 45 only, whereas premiums on the \$31,800 continuous-premium whole life will continue beyond that time. At age 45 the cash value of the twenty-pay life policy is about \$10,100, whereas the cash value of the continuous-premium whole life is only about \$8,500. From then on, the cash value of the continuous-premium whole life will gain on the twenty-pay by reason of the continued premium payments. By age 60 the cash value of the twenty-pay will be about \$12,900, whereas the cash value of continuous-premium whole life will have grown to about \$16,400. At age 65 the twenty-pay policy will have only about \$13,800 available for retirement benefits. The continuous-premium whole life, however, will have a retirement fund of about \$19,000.

On the other hand, for the first twenty years, the twenty-pay policy will have a higher total cash value than will the continuous-premium policy, which might make a difference in case of an emergency need for cash.

The decision as to which type of policy to buy depends, therefore, on whether the need of the buyer (and especially of his family) is more for cash values or more for protection against both the peril of living too long and the peril of dying too soon.

The limitations of limited-payment life policies are, therefore, those which arise from erroneous use. The greatest error in the use of these forms is made by people who should place the emphasis in their insurance program upon premature death protection rather than savings.

Limited-payment life policies are more popular than term, but less popular than continuous-premium whole life. Exclusive of group and credit life insurance, limited-payment life accounts for about 27 per cent of the life insurance in force. Contrary to what would be expected on the basis of sound insurance buying theory, limited-pay life policies are purchased largely by low-income groups and those under age 30.

Single-Premium Life Policies. Single-premium policies are contracts issued in exchange for the payment of the entire cost in advance through one lump sum premium. For example, a \$20,000 participating single-premium whole life can be purchased at age 35 for about \$10,575.¹² Once this premium is paid, no more premiums are required during the life of the policy.

Single-premium policies must not be confused with policies under which premiums have been discounted in advance. Many companies, by contractual agreement or as a matter of company practice, will accept a given number or amount of annual premiums in advance of their due date. The companies credit these advanced premium deposits with interest earned at each policy anniversary date. A minimum interest rate ranging between 2 and 3 per cent may be guaranteed. For example, the above \$20,000 whole life contract can be

¹² The rates and cash values quoted in this section are based on the rate manual of a prominent participating company. They vary slightly from company to company.

purchased on the twenty-pay plan for an annual premium of about \$780. The insured by depositing a lump sum of \$13,109 with the company can discount these twenty annual premiums and in effect own a paid-up policy.¹³

Although both policies require no more premium payments, the two contracts are quite different. The twenty-pay contract with premiums discounted in advance costs \$2,534 more in premiums than the single-premium policy. The cost differential is explained by the higher death benefit payable under the prepaid twenty-pay life during the first twenty years it is in force. As to death benefits, the two policies function in this manner:

When a single-premium policyholder dies, his beneficiary is paid only the face value of the contract. But upon the death of an insured whose premiums have been discounted, his beneficiary is paid the face of the policy plus a refund of the present value of unearned premiums. For example, if the insured dies at age 45, \$20,000 will be paid under the single-premium policy, whereas the discounted premium policy will pay about \$27,198. This \$27,198 figure includes the \$20,000 of insurance plus the value of the ten unearned premiums of \$780 discounted at 2 per cent for nine years.¹⁴

The redemption values of the discounted policy also are higher during the first twenty years, since the present value (or a percentage thereof) of the unearned premiums is refundable along with the cash values of the policy. For example, at the end of the tenth year, the discounted policy has a cash value of \$5,828 plus \$7,196 of unearned premium or a total of \$13,024. The single-premium policy has a cash value of only \$11,027. At the end of the nineteenth year, the twenty-pay policy has a redemption value of \$13,039 including \$780 of advanced premiums. The cash value of the single-premium contract is \$12,685.

At the twentieth year, when the advance premiums have been exhausted and all premiums are paid, the death benefits and cash values of the two contracts are identical. They both will pay \$20,000 at death, and at the end of the year they will have a cash value of \$13,061. From then on, the increases in cash values will be the same in the two contracts.

A tax advantage provides an incentive for discounting premiums. The interest earned by discounting premiums is not reportable as income under federal tax laws. For people in high tax brackets, 2 or 3 per cent compound interest is equivalent to a much higher effective rate of return on other investments.

Uses of the Single-Premium Life Policy. At first blush, one would wonder why anyone would want to purchase life insurance on a single-premium basis. Admittedly, the idea of paying the entire premium in one lump sum would

¹³ Actually only nineteen premiums are discounted, since the first-year premium is paid in advance.

¹⁴ Since one of the ten unearned premiums is due immediately, only nine are discounted.

never occur to the typical person. Such a premium-paying arrangement would be neither desirable nor practical in most instances. Nevertheless, there are several legitimate uses for single-premium insurance. For example:

(1) Since life insurance has many attributes desirable to persons interested in an investment, the single-premium policy might be an attractive investment medium for some investors.¹⁵

(2) Single-premium life insurance is sometimes a good place to put "windfall profits" that do not occur regularly, and therefore do not justify an increase of the annual premium insurance budget. A lawyer, for instance, who collects an unexpected \$5,000 fee or a life insurance man who closes a pension case yielding a \$5,000 first-year commission could well afford to invest these funds in single-premium life insurance. In this way, they would maintain the fund's liquidity¹⁶ while, at the same time, buying for themselves an investment with a guaranteed interest return, automatically compounded, which offers a chance of high speculative gain in case of premature death.

(3) The single-premium plan sometimes is used to purchase life insurance to offset death taxes and the costs of distributing an estate.¹⁷ The purpose of single-premium insurance in this case is to put the maximum liquidity into an existing estate. Funds for the payment of single premiums often are obtained through the conversion of other investments. Such changes in the character of investment accounts might well be warranted. One of the primary requisites of an investment ear-marked to pay estate taxes is liquidity. Liquidity is defined as the ability of an asset to be converted into cash without delay and without loss in value. Life insurance more than meets this liquidity test, for not only does it automatically convert into cash at death when the cash is needed, but also it does so with an increase in value. Life insurance is always worth more at death than immediately preceding it.

(4) Single-premium life insurance also is used as a gift medium, particularly for children. At young ages, large amounts of life insurance can be obtained for a relatively small premium. For instance, one company quotes a gross, participating, single-premium life rate of \$323 per thousand at ages under six months. In other words, a paid-up life insurance estate can be purchased for an infant for just slightly more than 30 cents on the dollar. Moreover, such an estate will give him cash values for emergencies that might arise during his life and, in the case of participating policies, it will also give him a small income in the form of policy dividends which he may either take in cash, leave on deposit with the company at interest, or use to buy paid-up additional insurance.¹⁸

¹⁵ Cf. Chapter 7 for a discussion of the investment features of life insurance.

¹⁶ Except for the first few years when there is, in effect, a charge for cashing in the policy, which charge covers unamortized acquisition costs.

¹⁷ Annual-premium insurance can also be used for this purpose; but the single-premium plan requires no further premiums, sometimes an advantage in particular estate arrangements. (Cf. Chapter 17)

¹⁸ Cf. Chapter 10 for a discussion of dividend options.

Limitations of the Single-Premium Life Policy. Single-premium insurance has serious limitations when used by the typical individual in the typical life situation. The single premium for \$1,000 of life insurance at age 25 would pay the initial annual premium on \$30,000 or so of continuous-premium whole life insurance. Let it be repeated, again, that the need of the typical individual aged 25 is for all the premature death protection he can possibly pay for, rather than for high cash values or even paid-up policies.¹⁹ In general, single-premium is used validly only when premature death protection needs are substantially taken care of or where the money used consists of funds derived from a nonrecurring source. As an investment medium, its limitation is the same as other fixed value investments (bonds, mortgages, building and loan shares, etc.). It leaves the investor exposed to the perils of inflation. On the other hand, it offers excellent protection against deflation.

2. PREFERRED RISK AND SPECIALS.

Until the 1950's the general philosophy of the life insurance business was to charge persons of the same age, who were standard risks, the same rate per \$1,000. Policies offering a reduced rate have been available, however, to certain applicants since the early 1900's. For the most part, these policies were limited to persons who were preferred risks and were known as "preferred risk" policies.

The term "standard risk" is applied to those applicants whose health, habits, and occupation are similar to those upon whose mortality experience the mortality table in use was compiled. It has long been the practice to charge an extra premium to those who fail to meet the standard and refer to them as "substandard risks." A "preferred risk" is "superstandard" underwriting, the reverse of the substandard philosophy. It offers a reduction in rate for the applicant whose health, habits, and occupation are better than "standard."

A "preferred risk" is a *special* policy, i.e., not the "regular" policy issued by the company. However, under the impetus of a price-merchandising wave which started sweeping the business in the 1950's,²⁰ companies began issuing "special" policies, the rate of reduction for which is affected by any one or combination of factors in addition to or other than "superstandard" underwriting. In fact, many "specials" (as the term is now used) are even issued with substandard underwriting.

The Nature of "Specials." The "special" is usually a policy offered in a

¹⁹ The stress here and elsewhere on the need of the younger man for protection as contrasted to cash values should not necessarily be interpreted as advocacy of term in contrast to permanent insurance. While term offers the largest death protection per premium dollar, it ignores two facts (1) With improvements in mortality, more and more policyholders are living to retirement ages, for which term offers nothing, and (2) term offers practically no emergency values.

²⁰ Or, at least, became widespread enough at that time to cause controversy in the business.

high minimum amount, carrying a rate sharply reduced over a similar, or the same, form issued on a regular basis, and showing a favorable net cost,²¹ especially at periods common for such comparisons—at the end of ten and twenty years.

Table 7, which follows, illustrates the premiums for a life paid up at 85, a “special” issued only in a minimum of \$25,000 not requiring superstandard underwriting, compared with a regular life paid up at 85 in another company. Both sets of premiums are on a participating basis.

TABLE 7.

Comparison of Rates per \$1,000

(Life Paid Up at 85, \$25,000 Minimum “Special,” and
Regular Life Paid Up at 85, Both Par Basis)

<i>Age of Issue</i>	<i>Special (Company A)</i>	<i>Regular (Company B)</i>
25	\$16 95	\$20.59
35	22 97	27.57
45	33 59	38 83
55	50 70	57 95

Methods of Reducing Rates. Several methods are available by which reduction in the premium rate for the “special” is achieved:

(1) *A high minimum amount will be issued*, thus spreading the fixed costs of acquisition (clerical, etc.) over a greater number of units. (There are some acquisition costs that are the same whether the policy is written for \$1,000 or \$100,000. Typing the policy can be cited as one example.)

(2) *Commissions to agents are reduced.*²²

(3) *A reduced gross premium on a participating plan* is brought about by a reduction in expense allowance (which, however, will be offset if dividends are also reduced).

(4) *Cash values are reduced.*

(5) *Installments are reduced under settlement options:* for example, one company guarantees a life income of \$5.86 per \$1,000 at age 65 (male) on its “special,” whereas it offers \$6.32 on its regular policy. In some policies, settlement options are omitted from the contract altogether. The policy provides, instead, that if an installment settlement is desired, whatever tables are currently in use by the company will apply.²³ Other “specials” reduce the number of settlement options offered in the policy in order to reduce the cost of handling the policy.

²¹ Total premiums paid, minus total dividends, if any, minus cash value at the time selected for making the illustration.

²² Reporting on a survey of 134 companies several years ago, the Life Insurance Agency Management Association stated that commission rates were reduced on “specials” by 42 per cent of the United States companies with \$1,000,000,000 or more of insurance in force, 60 per cent of those with \$150,000,000 to \$1,000,000,000, and 65 per cent of those with less than \$150,000,000. Commission rates were reduced by 7 per cent of Canadian companies.

²³ This prevents the possibility that improved mortality or deteriorating interest rates will make the options in use at the time of issue, unrealistic twenty-five years or more in

(6) *Payment of a "settlement" dividend* (also called a "terminal" dividend), payable only if the policy is surrendered at the end of a specified number of years or at maturity or death.²⁴ Such a dividend will produce a particularly favorable net cost illustration if it is made available at the end of the number of years at which net cost illustrations are commonly constructed—ten and twenty, as previously noted.

"Minimum Deposit" Policies. A special type of policy, not ordinarily classified as "special," is the "minimum deposit" plan. This is a high cash and loan value form, usually offering a loan value upon payment of the first premium. Such policies were devised primarily to be used by buyers who wished to finance the first-year and subsequent premiums by borrowing on the values in the policy, either from a bank or from the insurance company. Under this plan, the policyholder has to put out in cash only the difference between the loan or collateral value of the policy, plus interest, and the total premium. The interest on the loan effected to finance the premium is a deductible expense for federal income tax purposes.

Not at all new in principle, the procedure gained great popularity in the mid-1950's, but quickly came into disrepute as inordinate amounts of this insurance were sold to persons who were unlikely to understand what they were buying and who were interested primarily because of the tax deduction angles.²⁵ Treasury Department interest in the possibility of undue tax avoidance, criticism within the business itself, and state department scrutiny (especially in New York) led to withdrawal of the form by many companies and definite restrictions on its placement in others.

Gradation of Premiums. It was not too great a step from the principle of reduction of premiums for "specials" by reason of size of policy to gradation of premiums by size for all policy forms. This latter development, a practice long established in Europe, followed quickly on the heels of "specials" in the second half of the 1950's.²⁶

The practice of reducing premiums by size of the policy has become widespread.²⁷ Several methods are in use:

(1) There is gradation by minimum size, as in the case of the "special"

the future when the policy matures. Many policies today are being paid out under installment options set many years ago using annuitant mortality and interest guarantees the company can no longer realize, thus serving as a source of loss to the company.

²⁴ The payment of such a dividend after death should not be confused with a post mortem dividend, which is (roughly put) the deceased policyholder's pro rata share of the policy dividend he would have received had he been alive at the end of the policy year.

²⁵ While perhaps oversold on tax-avoidance appeal, the plan was not without its merits in cases in which the buyer understood exactly what he was doing (which included the possibility that he might reach retirement age with insurance so encumbered that it was valueless) but who still wished to get needed protection in force immediately.

²⁶ All such dates as these are "in general." It is always possible to find some few companies instituting a practice before any given date.

²⁷ This is akin to the practice of mercantile "quantity discounts," but is not related to the practice of reduction of premiums by size in many phases of property insurance. For instance, the premium for the first \$10,000 of personal liability insurance is more

that offers a lower rate per thousand for, say, \$25,000 than for reasonably comparable coverage under \$25,000.

(2) "Band" gradation is possible, under which reductions are made by "brackets": say one rate applying for any given policy issued in an amount under \$5,000, another for policies in amounts from \$5,000 to \$15,000, another from \$15,000 to \$50,000, etc.²⁸

(3) Under "across-the-board" or "per \$1,000" gradation, rates are reduced on each subsequent \$1,000 of face amount issued.

(4) A flat charge per policy may be made, under which a fixed dollar factor or charge is added to each application. Thus, if the application is for \$2,000, the per-policy charge is less per \$1,000 than if it is for \$3,000. For instance, if the issue charge (rarely called that but given some more euphonious name) is \$8.00, it is \$4.00 per \$1,000 on a \$2,000 policy but only \$2.67 per \$1,000 for a \$3,000 policy and only 16 cents per \$1,000 on a \$50,000 policy.

3. SUMMARY.

As contrasted to protection limited in duration, as is the case in term and endowment, whole life offers protection throughout the life span of the insured. Whole life policies may be classified on the basis of the time period over which premiums are paid. If premiums are payable continuously for the whole of life, the policy is often called "ordinary life" or "straight life." However, the most descriptive name is "continuous-premium *whole life*," because that name distinguishes it from the limited payment forms. Continuous-premium whole life is the most flexible of all policy forms. It offers the insured the opportunity to buy the maximum permanent premature death protection for a given outlay, while also building a fund for retirement. Its only limitation is that it sacrifices some premature death protection for a retirement fund. Obviously, this is no disadvantage unless the policy is used by families which must cut premature death protection below minimum standards needed in order to afford the higher premiums required to build the retirement fund.

Limited-payment life policies are those that require premium payments for a specified maximum number of years (most commonly twenty or thirty) or until the insured reaches a given age (most commonly 60 or 65). The limited-payment life policy has the advantage of building up a savings fund at a faster pace but has the limitation of encouraging the insured to sacrifice necessary premature death protection in order to enjoy these greater living benefits.

Single-premium life policies are contracts under which the entire pre-

than for, say, the second \$10,000, but this is not a "quantity discount." The reduction is based on the statistical fact that more claims in amount up to \$10,000 will be paid than claims over \$10,000. However, the frequency of occurrence of a \$1,000 death claim in life insurance is exactly the same as that for \$100,000.

²⁸ "Bands" mentioned here are illustrative only, not intended to represent typical practice.

mium is paid at their inception in one lump sum. Single-premium life is principally an investment contract and offers holders of capital funds many investment advantages. Single-premium insurance is used as a gift medium. It also is used by men of wealth to achieve estate liquidity for meeting death taxes and other costs of dying. Although single-premium life insurance qualifies as a depository for capital accumulations and windfall incomes, it does not fit into the life insurance program of the typical family seeking to achieve a balance between premature death protection and old age security through its life insurance, which must be purchased with carefully budgeted premium dollars.

In recent years there has been an increased activity among companies in issuing reduced-rate policies known as "specials." Formerly contracts with reduced premiums were called "preferred risk" contracts, since they were issued only to applicants who appeared to be superior underwriting risks. Today, these "discounts" have been extended upon other grounds.

In addition to or in place of restricting the contract to superior underwriting risks, companies can use various devices to reduce premiums. lower commission, less loading for expenses, surrender dividend, lower cash values, restricted settlement options, restricted service, and a large minimum policy. It is clear that a buyer of insurance must look to more than price in selecting an insurance contract. A "special" might do the job desired in a given program; but unless the policy, "special" or "regular," meets the need, one would do well to look elsewhere.

Another method of reducing rates is "quantity discounts," a system in which the size of the face amount of the policy has a bearing on the rate per \$1,000. The rate reductions may be effected by "bands," "across the board," or by addition of a flat charge per policy, which means a lower flat charge per \$1,000 as the amount of insurance increases.

QUESTIONS FOR CLASS DISCUSSION

1. It has been said that in buying insurance, one should apply the following rule: "Buy as much premature death protection as you need, and pay as much for it as you can afford." Explain the reasoning behind this rule and indicate whether or not you agree with it.
2. A common objection to continuous-premium whole life is summed up in the statement, "I don't want to pay premiums all my life." How would you counsel a young man who has just been sold a continuous-premium whole life?
3. It has been said, "When a young man aged 25 buys a twenty-payment life policy, you can bet your last dollar that he has bought the wrong contract." Explain why you agree or disagree with this statement.
4. Under what set of circumstances would you recommend the purchase of a limited-payment life contract?
5. Explain how a minimum deposit plan can appeal to buyers in high tax brackets.

How does the use of a policy loan to finance the premium resemble the purchase of decreasing term insurance?

6. Mike Cassidy is faced with the decision whether to put his \$2,000 inheritance into single-premium life insurance or United States Government bonds. What factors would you suggest that he weigh seriously in reaching a decision?
7. Assume that Mike Cassidy is considering a choice between single-premium life insurance and the common stock of a well-established corporation. What factors would you suggest he consider in reaching a decision?
8. James Moore is considering three \$50,000 contracts: twenty-payment whole life, term to age 65, and single-premium whole life. From an underwriting standpoint, which would you expect would be (a) the most difficult to get, and (b) the least difficult to get?
9. Explain why you agree or disagree with the following statement: "The retirement values in a life insurance policy are a function of the kind of policy taken as well as of the amount of insurance taken."
10. B. J. Wright at age 35 has been offered a \$10,000 "special" whole life contract (continuous-premium whole life) for an annual premium of \$235. Another company offered him its regular continuous-premium whole life for \$276. What features relating to these two policies should Wright look into before reaching a decision as to which one to buy?

CHAPTER 5

The Annuity Policy

The annuity has become an important instrument in planning financial security for old age. The increasing emphasis placed by labor and management on industrial pensions has accounted for much of the growth in annuities over the past decade. Six million annuities are in force representing in the neighborhood of \$2,500,000,000 of future annual income. Over two-thirds of this amount is provided under group annuities.

1. THE NATURE OF ANNUITIES.

The annuity has been called the “upside-down application of the life insurance principle.” The description is apt. Whereas the purpose of a life insurance contract is the systematic accumulation of an estate, the purpose of an annuity contract is the scientific liquidation of an estate. One function is as important as the other because the family which improperly liquidates its estate may suffer eventually as much as the family which has no estate at all.

When a person purchases a life insurance contract, he agrees to pay the insurer a series of payments in return for which the insured will, at his death, pay his beneficiaries a specified capital sum. When he purchases an annuity contract he pays the insurer a specified capital sum in return for a promise from the insurer to make him a series of payments as long as he lives.¹ Thus, under a life insurance contract the insurer *starts* paying upon the death of the insured, whereas under an annuity contract the insurer *stops* paying upon the death of the insured.

Like life insurance, the annuity is a risk-sharing plan based upon a group, the individual members of which are all the same age. Individually, these people could not draw upon principal without fear of outliving it. Under a risk-sharing plan, the funds of those who die early can be used to offset the excess withdrawn by those who live long after their principal is spent. While the insurance company does not know how long any one given individual member of the annuity group will live, it does know how to apply the law of

¹ Obviously this is a simplification for the sake of illustration. The life insurance premium may be made in one payment as well as in a series, the contract may provide for payment of the lump sum at the end of an endowment period as well as at death; and the payment may be made in installments instead of a lump sum. The annuity premium may be paid in installments as well as in a lump sum, some types of annuities pay for a limited period, expiring regardless of whether the annuitant is still living, and some continue payments to a surviving beneficiary. See Section 2 on classification of annuities.

large numbers to the experience of a specific group of annuitants so as to approximate the actual result for that group. Therefore, when the savings or investments of a large number of individuals are combined, each member can be paid an annual or monthly amount, actuarially calculated to assure that no one will outlive his capital or income; yet the capital will be paid out and not hoarded. Thus, uncertainty is reduced, and losses (the costs of "living too long") are shared.

The amount of periodic income drawn by each member of the group is determined not only by his contribution but also by his age, sex, and type of annuity selected. The older a person is when he begins to receive his annuity income, the greater will be his periodic payments per dollar of contribution. A man will draw more periodically than a woman of the same age, per dollar of contribution. And if the annuitant is willing to have his payments terminated at his death, he will receive a higher periodic income than if he insists on a guaranteed minimum number of payments.

Annuity Income. The periodic income collected under an annuity contract is composed of three parts. principal, investment income, and a survivorship or insurance benefit. The amount attributable to each part from any given periodic payment may be computed easily. To illustrate, assume an annuity of \$1,000 a year issued to a man aged 65, with first payment due one year from date of issue. The cost of the annuity would be \$8,380 figured on the basis of 3 per cent interest and the Combined Experience (Actuaries) Table. If the annuity were purchased one year later (at age 66), the net single premium would be \$8,030. *Thus, in the first year, \$350 of the original capital has been liquidated.*

Segregation of the first \$1,000 periodic payment into principal, interest, and survivorship benefit would be figured as follows:

Initial Investment (net)	\$8,380 00
Interest Assumed (3%)	+ 251 40
Total Amount Available	\$8,631.40
Annuity Payment	— 1,000 00
Amount Remaining Without Survivorship Benefit	<u>7,631 40</u>

Note that the net cost of the annuity at age 66 would be \$8,030 but that only \$7,631.40 are available. How is the deficiency of \$398.60 replenished? Not all of the 65-year-old annuitants will survive the one-year period to collect their \$1,000. Those who die will release their investment to be spread among the survivors. Each survivor's share will amount to \$398.60, which is the deficiency in the fund available at the beginning of the second year.

Thus the first annuity payment of \$1,000 is divided as follows:

Interest Income	\$ 251 40	(\$8,380 at 3%)
Capital Liquidation	350.00	(\$8,380 00 — \$8,030.00)
Survivorship Benefit	398.60	(\$8,030 — \$7,631.40)
Total	<u>\$1,000.00</u>	

Each successive year the survivorship benefit will increase, whereas the interest income and capital liquidation will decrease. For example, the annuity payment for the second year will consist of:

Interest Income	\$ 240 90	(\$8,030 at 3%)
Capital Liquidation	330 00	(\$8,030 — \$7,700 *)
Survivorship Benefit	429.10	(\$7,700 + — \$7,270.90 †)
Total	<u>\$1,000 00</u>	

* \$7,700 is the cost of the annuity at age 67

† \$7,270.90 is the amount remaining from the initial fund plus interest after the \$1,000 payment is made

The division of payment for each successive year can be worked out using the method applied above. The formulas for each part are as follows:

Interest Income = Net Single Premium at the beginning of the year multiplied by the interest rate assumed.

Capital Liquidation = Net Single Premium at the beginning of the year less the Net Single Premium one year later.

Survivorship Benefit = Net Single Premium one year later less the Net Single Premium at beginning of the year plus assumed interest minus assumed annuity payment

The purpose of an annuity is to assure a person an income he cannot outlive and one which is well in excess of the income he could derive from investing the cost of the annuity in safe, interest-bearing or dividend-yielding securities.

The periodic income under the annuity is larger than that provided under direct investments because the annuity principle involves the gradual consumption of the invested capital. The differential between the annuity income and income from direct investments is slight at young ages because the annuity payments are to last through the insured's lifetime, which means that only a small part of the capital can be consumed each year. Neither will there be much survivorship benefit to cause the annuity payment of be much in excess of the interest income. For these reasons, an annuity cannot be considered a suitable investment for a young person. At older ages, especially at the retirement ages of 60 to 70 when life expectancy is lower, the differential is more pronounced. For example, \$40,000 would purchase an immediate life annuity of only about \$130 a month for a man aged 40, as contrasted to about \$255 a month if the purchase is delayed to age 65. A conservative 3 per cent investment would bring \$100 a month in each case. While the difference of about \$155 a month between the annuity income and the straight investment income at age 65 may be large enough to warrant the sacrifice of the principal sum, a difference of only about \$30 a month may provide insufficient motivation.

2. ANNUITY CLASSIFICATIONS.

Up to this point, the discussion has been concerned with the annuity in its simplest form, the single premium life annuity contract. Under this contract,

the insurance company promises to pay a given amount each period (monthly, semi-annually, etc.) to the annuitant during his lifetime, in exchange for a single premium which immediately becomes the property of the company, no part of which is returnable following the death of the annuitant, whenever that occurs.

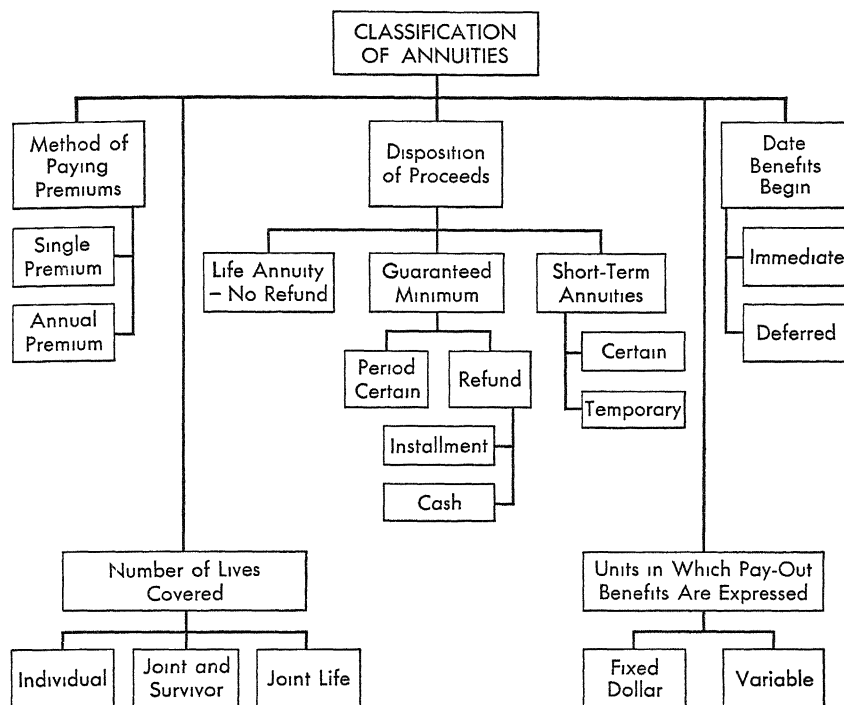
The single premium life annuity contract, however, does not meet the economic or psychological needs of *most* annuity purchasers. Some buyers want to pay for their retirement annuities through a series of level annual premiums during their preretirement years. Some do not like the idea of having no part of their premiums returnable to their estate in the event of early death following retirement. A few purchasers would like to have the annuity payments contingent upon the lives of more than one person. Still others would like to have the amount of each annuity payment measured by units which fluctuate in dollar values. Because of the variety of interests among annuity customers, a number of variations in annuity forms has developed.

Since there are many types of annuities, and since any given annuity contains a combination of features from each of the several types, a classification system becomes necessary to an orderly discussion. Annuities may be classified on five different bases: the method of paying premiums, the disposition of proceeds, the date that benefits begin, the number of lives covered, and the units in which pay-out benefits are expressed. The following chart on page 83 is a useful device for viewing the annuity types as a unit.

Method of Paying Premiums. Annuities may be purchased either with a single premium or through a series of installment premiums.

Single-Premium Annuities. An annuity purchased by one lump sum is known as a single-premium annuity. Frequently life insurance cash values or death proceeds are distributed under a settlement option, in the form of an annuity (the life income option). Here the lump sum is used, in effect, to purchase a single-premium annuity at net rates. For example, instead of a lump sum settlement, \$25,000 of life insurance proceeds could be paid to a 55-year-old widow as a life annuity of about \$106 a month. A 65-year-old man could have his \$25,000 of life insurance cash or endowment values paid to him as a life annuity of about \$162 a month.

The single-premium annuity is frequently used in pension and profit-sharing plans. It may be used to fund retirement benefits at the time an employee retires. For example, an employer can fund a retirement pension of \$150 a month for a male employee aged 65 for a single premium of about \$18,000. Single-premium annuities also can be used to fund a series of fully paid benefits deferred to age 65, financed from annual contributions made by employers and employees. For example, a contribution of \$250 on behalf of a male employee aged 35 would purchase a fully paid annuity of about \$3.25 a month commencing at age 65. At age 50, \$250 would purchase a fully paid



life annuity of only about \$2.25 a month, deferred to age 65. Aside from the liquidation of life insurance proceeds and cash values and the funding of industrial pensions and profit sharing plans, the market for single-premium annuities is not large. Not too many people are in circumstances that would make them prospects for single-premium annuities.²

Annual-Premium Annuities. By far the most popular type of annuity in the individual field is the annual-premium annuity. In this form the premiums are paid in periodic installments over the years prior to the date on which the annuity income begins.

The annual-premium deferred annuity is a flexible instrument. It is usually written as a savings contract during the period of accumulation: there are no forfeitures either at death or surrender during this period. Consequently, there are no benefits for surviving the period. If the annuitant wishes to terminate his obligation to pay premiums, he may select a paid-up annuity for a reduced amount or withdraw the surrender value. If he should die before the contract passes from the accumulation to the liquidation period, his beneficiaries are entitled to a death benefit equal to the cash value of the

² Only 20 per cent of the individual deferred annuities are of the single-premium type, whereas almost 95 per cent of the group deferred annuities are of the single-premium type. Over 26 per cent of the annuity income now being paid to annuitants is being distributed under life insurance settlement options.

contract or the amount of premiums paid in, whichever is higher. The contract has one further flexible feature: usually, the annuitant may elect to have his income payments start earlier or be postponed until later, with the necessary actuarial adjustment downward or upward in the amount of the benefit.

The annual-premium annuity appeals to the client who wishes to use the annuity instrument as a vehicle for estate accumulation as well as for estate liquidation. By its use he is guaranteed an annuity at today's rate. With longevity rates increasing, this guarantee could prove valuable. At present rates, a retirement annuity of \$100 a month commencing at age 65 would cost a man aged 25 just under \$250 a year when written on a participating basis.

Disposition of Proceeds. Annuities may be classified further on the basis of the time at which benefits stop. Under this classification are four types of annuities: the life-annuity-no-refund; the guaranteed minimum annuity; the annuity certain; and the temporary life annuity.

The Life-Annuity-No-Refund. The life-annuity-no-refund frequently is called a straight life annuity. The straight life annuity offers an income to the annuitant throughout his lifetime, regardless of how long that may be. At his death there is no equity in the contract regardless of how few benefit payments have been received. The entire purchase price of the annuity is considered earned by the company upon the death of the annuitant. This is the purest form of annuity and offers the annuitant the largest income payment per dollar of purchase price.

Psychologically, the straight life annuity is difficult to sell and conducive to misunderstanding. Annuitants, and particularly their heirs, sometimes feel that the company has "confiscated" the premium if the total income received does not equal the purchase price. The misunderstanding arises out of failure to comprehend the operation of the insurance principle—failure to understand that some of the premiums of those who do not reach their life expectancy are used to pay incomes to those who live beyond their expectancy. The annuitant stands the chance of falling into either one of these classes. If he is willing to sacrifice his unused principal for the benefit of those who survive him, he, in turn, will benefit from the release of funds by those whom he survives. Thus the benefit of survival is greatest in the straight life annuity. Be this as it may, few annuitants want to run the risk of fully dissipating principal in the event of early death following retirement.

Guaranteed Minimum Annuities. To meet the psychological and economic objections to the straight life annuity, two forms of guaranteed minimum annuities have been developed: period certain and refund. Refund annuities may be divided further into installment refund and cash refund.

A life-annuity-period-certain promises to pay an income for life but guarantees a minimum number of payments. For example, a life-annuity-ten-years certain always will make 120 payments (if written on a monthly basis)

irrespective of whether the annuitant lives or dies. If the annuitant lives, these payments will be made to him and will continue to be made until his death no matter how far off it may be. If the annuitant dies within the period certain, the remainder of the guaranteed payments will be made to his beneficiary. Thus, under such an annuity, if the annuitant himself were to die at the end of the eighth year, the monthly benefits would be continued to his beneficiary for two more years—or twenty-four months.³ But if the annuitant lives for twenty years, payments will continue for that length of time. Upon his death after the period certain, all benefits and values terminate. The cost of this guarantee depends upon the age of the annuitant when benefits commence. For example, a 120-month guarantee for a female aged 65 would cost between 6 and 7 per cent more than a no-refund annuity for the same monthly benefit. At age 55 the guarantee would cost between 2 and 3 per cent more, whereas at age 45 the difference would be less than 1 per cent.

A *refund annuity* may be either an installment refund or a cash refund annuity. An *installment refund annuity* promises to continue the periodic payments after the death of the annuitant until the combined benefits paid to the annuitant and his beneficiary have equaled the purchase price of the annuity. A *cash refund annuity* agrees to return in cash the difference between benefits received and the purchase price paid upon the death of the annuitant. In either case, if the annuitant himself lives long enough to collect the purchase price in annuity income, payments continue as long as he lives, but upon his death all benefits and values terminate. For example, a \$1,000-a-year installment refund annuity would cost about \$16,000 for a woman aged 65. If she died after having received six annual installments, her beneficiary would be entitled to ten more installments, making the total pay-out \$16,000, which is the purchase price of the annuity. Instead of ten annual payments of \$1,000 each, the beneficiary may elect to receive a lump sum cash settlement equal to the discounted value of the ten annual payments. If this were a cash refund annuity, the cost would be about \$16,350. In the event of the annuitant's death after having received six payments (\$6,000) her beneficiary would be entitled to collect \$10,350 in cash, thus completing the total pay-out of \$16,350. When the refund is made in cash instead of installments, interest on the monthly decreasing principal not yet paid is sacrificed by the company. Therefore, the cash refund annuity is more expensive than the installment refund. If this were a life-annuity-no-refund, the cost would have been only about \$14,000.

Life annuities certain and refund annuities often carry cash values equal, as a rule, to the discounted value of the unpaid, guaranteed installments or cash refund.

The choice between a guaranteed minimum annuity and a life-annuity-no-

³ The twenty-four monthly payments may be commuted (discounted for present value) and paid in one lump sum.

refund depends upon two considerations: (1) the age at which the annuity payments are to start, and (2) whether there is a need to provide for dependents.

In the case of a relatively young annuitant, the difference between the periodic income payments received from a refund annuity and a straight life annuity carrying the same premium is so small as to make the straight life annuity seem uneconomical. For the capital sum of \$10,000, a woman of 35 can purchase an annual income of about \$390 under an immediate installment refund annuity, whereas an immediate straight life annuity will offer her only about \$395 a year. The difference is insignificant. On the other hand, a woman of 65 can purchase an income of about \$637 a year with \$10,000 through the same installment refund annuity, whereas a straight life annuity will yield her \$713 a year for the same premium. The difference in this case is more significant.

There is a simple reason for the widening gap between incomes produced by refund annuities and straight life annuities as ages advance. The probability of an annuitant aged 35 surviving a twenty-year certain period is far greater than the chance of such survival by an annuitant aged 65. To put it another way, the older the annuitant is at the time the annuity commences, the less is the likelihood that he will outlive the period certain, and consequently the more the company will have to charge as a differential to pay the refund or some portion of it.

If an annuity is purchased where there are young dependents, a guaranteed minimum annuity is essential unless there is adequate life insurance or other estate assets.⁴ A straight life annuity completely liquidates the estate at the same time that death liquidates the annuitant himself. Nothing is left behind to care for dependents. A properly arranged refund annuity or life annuity certain for a parent leaves income to take care of the children should the parent die before such dependents achieve independence. For example, a ten-year certain life annuity for the parent of a ten-year-old son will guarantee that an income will be available to support the child until he is twenty years old, even if the parent should die in one or two years.

The Annuity Certain. The annuity certain is a contract which provides the annuitant with a given income for a specified number of years, independently of his life or death. Upon the termination of these years, the payments cease. Survival is in no way a factor. Therefore, if the annuitant should die before the expiry of the years indicated, the payments continue to the end of the stipulated period. This form of annuity is commonly used as a method of paying life insurance proceeds to a beneficiary under the fixed period or fixed amount options.⁵ For example, instead of having the proceeds of a \$10,000

⁴ Actually, where there are young dependents, there is no place in the life insurance program for an annuity of any kind, until and unless there is adequate life insurance to provide a new source of income when the head of the family dies, or unless the head of the family is uninsurable.

⁵ See Chapter 10.

life insurance policy paid to the beneficiary in a lump sum, the insured might direct that a series of fifty-five monthly payments of \$200 each be paid. In this way, he can assure his beneficiary an income over a fixed period of years, perhaps long enough to cover the critical child development period or to allow the widow to make a less abrupt adjustment to a lower standard of living. If the beneficiary dies before she has received the income for fifty-five months, the payments are continued to a secondary beneficiary until the end of the fifty-five-month period. If the primary beneficiary survives the fifty-five-month period, the payments are discontinued at that time.

Temporary Life Annuities. Temporary life annuities are similar to the annuity certain except that payments cease upon the death of the annuitant. A ten-year temporary life annuity will provide monthly payments for ten years or until the prior death of the annuitant, if earlier. These annuities are not popular, and therefore are rarely seen. Their uses are limited. One use is to provide an income to fill a gap until an income from another source becomes available. For example, a widow aged 47 with no dependent children might purchase a fifteen-year temporary life annuity to provide herself with an income until her social security benefits start at age 62, fifteen years later.

The Date that Benefits Begin. Benefits may be payable immediately after the contract is purchased, or they may be deferred until a number of years later.

The Immediate Annuity. The immediate annuity is purchased with a single premium, and benefits begin at the end of the first income period. For example, a man aged 65 could purchase a nonparticipating, no-refund immediate annuity of \$200 a month for about \$30,000. The monthly benefit will begin one month after purchase. If benefits are to start at the beginning of the first income period, the annuity is called an *annuity-due*. The annuity-due is used when life insurance proceeds or cash values are distributed under settlement options. Actually, with the exception of settlement options under life insurance contracts, few immediate annuities are purchased on an individual basis. On a group basis, however, immediate annuities are used in connection with deposit administration and immediate participation guarantee plans in pension administration ⁶

Many companies writing immediate annuities establish a minimum age at which they will be written. These minima range all the way from age 1 in some companies to age 45 in others. The most common minima are 20 and 30, with a number of companies establishing a minimum limit at age 10. Sometimes a company will set a minimum age limit five years higher for women than for men. Actually, there is good reason to restrict the age at which immediate annuities are written. As pointed out earlier, immediate annuities at young ages tend to be unattractive. There seems to be no point in liquidating capital, when direct, conservative investments would yield a periodic income no less or not much less than that paid by an annuity.

⁶ See Chapter 14.

When written as a straight life annuity, the immediate annuity is the simplest form of annuity contract. It provides for a regular payment throughout the lifetime of the annuitant, either annually, quarterly, or monthly. The first payment is made one year, three months, or one month after the date of purchase. Usually no proportionate payment is made for the fraction of a period from the date of the last regular payment to the date of death. There are no cash surrender values.

The Deferred Annuity. The deferred annuity may be purchased with either a single premium or an installment premium. The benefit payments begin at the end of a given number of years or at optional ages established in the contract. Thus, for example, a man aged 44 could purchase a \$100-a-month installment refund annuity to begin at age 65 with a single premium of about \$9,000. Or he could purchase the annuity for a series of twenty-one annual premiums of slightly more than \$600. Usually the deferred period is elected to correspond with the end of the annuitant's estimated income-producing period. If, for some reason, the annuitant wishes to shorten the deferral period, he may do so by accepting a smaller annuity. In the above illustrations, the annuitant could accept an annuity of about \$54 a month at age 55 if he has a single premium deferred annuity or about \$32 a month if his annuity is an annual premium annuity. An age 50 starting date would reduce the annuities to about \$42 and \$14 respectively.

Under the annual-premium deferred annuity, if the annuitant wishes to discontinue his premium payments before the annuity matures, he may do so by agreeing to accept a smaller annuity at age 65. To illustrate, in the above case the annuitant can discontinue premium payments at age 54 and take a paid-up deferred annuity at age 65 of about \$55 a month. If he discontinues premium payments at age 59, his paid-up annuity would amount to about \$78 a month.

Deferred annuities have two periods: the deferred period and the liquidation or pay-out period. Minimum guarantees can be made available in one of these periods, in both, or in neither. For example, assume a single-premium deferred annuity of \$100 a month commencing at age 65 issued at age 25 (male). The cost of this annuity would be only about \$4,100 if it were written without any guaranteed minima; that is, if no death benefits were payable during either the deferred period or period of liquidation. If the annuity guaranteed a return of the premium or cash value, if greater, upon death or withdrawal during the deferred period but was written only on a life-income-no-refund basis during the period of liquidation, the cost would be about \$5,300. But if the annuity not only guaranteed a return of premium or cash value at death or withdrawal during the deferred period but also guaranteed a minimum of 120 payments during the period of liquidation, the cost would increase to about \$5,800. It is customary in writing deferred annuities on an individual basis to guarantee a refund at death or withdrawal during the deferred period. Annuities written without cash refund at death or withdrawal during the deferred

period are unpopular with both insurance agents and buyers. As stated, the no-refund feature is conducive to misunderstanding. The buyer may feel "cheated" if, after paying premiums over a period of years, he gets no cash refund when he discontinues the plan.⁷ Whether there is any guaranteed minimum during the period of liquidation and the nature of any guarantee, is left to the discretion of the annuitant. Frequently this guarantee feature is flexible and the annuitant can make his choice any time before the annuity commences. Of course, the higher the guaranteed minimum selected, the lower will be the amount of each annuity payment. In the group field it is more common to find pure, deferred annuities; i.e., annuities written with no death benefits or cash values before retirement. Also in the group field, single-premium deferred annuities are common, whereas most individual annuities are annual-premium deferred annuities.

Number of Lives Covered. The usual annuity covers only one life. Situations do arise, however, when it is desirable to make annuity payments contingent upon several lives.

Joint and Last-Survivorship Annuity. The most popular type of annuity covering more than one life is the joint and last-survivorship annuity. Under this contract, income is payable throughout the joint lifetimes of two or more annuitants and continues until the death of the last survivor. For example, a man aged 65 and a woman aged 63 could purchase a joint and last-survivorship annuity in the amount of \$100 a month for about \$22,000. This contract will pay \$100 a month as long as either of them lives. Sometimes the contract will provide for a reduction in income payments upon the death of the first annuitant, say a one-third reduction, with two-thirds continuing to the survivor. Thus, if in the above example, it is felt that two cannot live as cheaply as one, the couple could arrange to have \$117 a month paid during their joint lifetimes and \$78 a month during the lifetime of the survivor. And this can be done without any change in premium. Commonly, joint and last-survivorship annuities are written on two lives—usually husband and wife—in order to guarantee income to both as long as either may live. This type of annuity option is frequently found among state and industrial pension plans. It is also used as a method of receiving cash or endowment values of life insurance policies to provide husband and wife with a joint retirement income.

The Joint Life Annuity. A type of annuity not frequently written is the joint life annuity. This annuity contract provides for payments which continue

⁷ From a sociological standpoint, it is regrettable that the no-refund feature of straight life deferred annuities is so misunderstood. If the premiums of those who die during the accumulation period could be used to provide retirement benefits for those who survive the period, the cost of providing old age security would be reduced substantially. The way retirement annuity contracts are presently constructed, the insurance feature is eliminated until the annuity payments commence. A man aged 35 who buys a retirement annuity contract actually gets no insurance by surviving to age 65. He gets only his contributions, plus interest, which are applied on an annuity at age 65. How much real insurance he gets after age 65 depends upon whether or not the refund feature is also included during the period of liquidation.

throughout the joint lifetimes of two people but cease upon the death of the first. There are no benefits to the survivors. This type of annuity is valuable when there is an independent income sufficient to support one member of the family but insufficient for both.

Units in Which Pay-Out Benefits Are Expressed. Under this classification annuities are of two types, fixed and variable. The terms "fixed" and "variable" have reference to dollars and not to purchasing power.

The Fixed-Dollar Annuity. The fixed-dollar annuity, sometimes referred to as the conventional annuity, guarantees the annuitant a fixed minimum number of dollars during each pay-out period. The guaranteed amount remains the same throughout succeeding periods of deflation or inflation. For example, a fixed-dollar annuity of \$200 a month will pay \$200 a month regardless of the purchasing power of the dollar.⁸ The assets behind these annuities are invested for the most part in fixed-dollar obligations such as bonds and mortgages.

Although a number of people still look to the guaranteed lifetime fixed-dollar income as the riskless method of providing retirement security, others fear that the fixed-dollar income as a medium for expressing retirement benefits may become technically obsolete in view of what seems to them to be a continued trend toward inflation. Cost-of-living indexes indicate a wide fluctuation in the value of the dollar over the long periods of time involved in building and liquidating a retirement program. How, advocates of the variable annuity ask, can a 35-year-old man determine today how many dollars he will need for a minimum retirement income thirty years from now? Even a 65-year-old man would not find it easy to determine how many dollars he will need over his period of retirement. Realistic planning for financial security in the later years, they contend, requires a full appreciation of the need to provide a satisfactory income in terms of its purchasing power at the time it is to be spent.

The Variable Annuity. When a contract seems to a large number of people to fall short in performing the function for which it has been designed, efforts will be made to develop one that will measure up to expectations. In 1952 the College Retirement Equities Fund (CREF) was created by a special act of the New York Legislature⁹ as a nonprofit educational corporation to write variable annuities for employees of colleges and universities. The variable annuity was to be the new type of contract to supplement the fixed-dollar annuity as an instrument for financing retirement pensions. CREF's basic tenet is that, since equities tend in the long run to fluctuate with price levels, an annuity from which the payments are geared to the performance of com-

⁸ If written on a participating basis, the amount paid under the annuity can be slightly higher than the guaranteed amount if dividends are paid.

⁹ *Laws New York 1952*, c. 124. CREF is subject to Arts 1, 3, and 16 and Secs. 59, 66, 78, and 214 of the New York Insurance Law. CREF was organized by and is a subsidiary of the similarly nonprofit "TIAA," Teachers' Insurance and Annuity Association.

mon stocks is likely to be a useful vehicle for funding retirement plans, especially when combined with a fixed-dollar annuity¹⁰ And since retirement planning is a long-range operation, intermittent fluctuations in business activity have little significance because the long-run trend is toward a continued erosion of dollar values with each cyclical inflationary peak higher than the last one.¹¹

The Variable Annuity Principle. Under the variable annuity plan the contract is expressed in terms of units rather than in terms of fixed dollars. Two types of units are employed—accumulation units and annuity units. When the annuitant pays his monthly premium, he is credited with a number of accumulation units, the amount to be determined by the then current value of one unit. For example, if the monthly net premium is \$50 and the current value of a unit is \$10.00, he is credited with 5 units. If the current value of a unit is \$9.52 when he pays his next \$50 premium, he is credited with $5\frac{1}{4}$ accumulation units. If the value of the unit is \$10.42 when he pays his third premium, he adds $4\frac{4}{5}$ units. The method of evaluating the accumulation unit is fixed in the contract.¹²

When the annuitant reaches retirement age, annuity units are substituted for accumulation units. The number of annuity units payable under the contract is determined by using well-accepted actuarial principles with regard to anticipated longevity of annuitants, and depends also, of course, upon the number of accumulation units credited under the contract. Just as it is possible to use actuarial principles to determine that \$16,000 of cash value ac-

¹⁰ The premise that benefit payments under a variable annuity will tend somewhat to vary directly with cost of living is derived from historical studies relating to "long-term" correlations in the movement of average prices of selected common stocks and cost-of-living indexes (see William C. Greenough, *A New Approach to Retirement Income* [New York: Teachers' Insurance and Annuity Association of America, 1951]). For a discussion of some strong economic arguments against the variable annuity see William A. Berridge, "Economic Facts Bearing on Some 'Variable Annuity' Arguments," *Journal of Insurance*, Vol. XXIV, No. 2 (November, 1957). For an appraisal of the pros and cons of the variable annuity see Robert I. Mehr, "The Erosion of Annuity Values," *Current Economic Comment*, Vol. XIX, No. 1 (February, 1957) (Bureau of Economic and Business Research, University of Illinois).

¹¹ Robert J. Meyers, chief actuary of the Social Security Administration, in commenting upon the CREF philosophy of combining the fixed and variable annuity to provide some hedge against both inflation and deflation, states "While the combination method does have some advantages in producing stability, the historical experience indicates that this was of relatively minor importance in comparison with the great advantage that the [variable] annuity would have had in keeping up with the cost of living." (*Transactions of the Society of Actuaries* [1952], IV, 772.)

¹² The accumulation unit was valued initially at \$10 by CREF. Over the past nine years, the CREF accumulation unit was fluctuated as follows.

Year	High	Low	Year	High	Low
1952	\$10.52	\$ 9.59	1957	\$20.50	\$17.50
1953	10.37	9.35	1958	24.36	17.92
1954	14.85	10.74	1959	27.11	24.22
1955	18.06	14.79	1960	27.24	24.84
1956	20.83	17.30			

cumulated under a conventional deferred annuity will pay a 65-year-old man a life annuity of \$100 a month, it is also possible to use the same principles to determine that 16,000 units of something else—francs, green stamps, bushels of corn, or simply abstract units as represented by the accumulations described here—will pay a man 65 years old a life annuity of 100 units a month. As in the case of the accumulation unit, the method of evaluating the annuity unit is a matter of contract.

The Accumulation Unit. The “accumulation unit” is used as a statistical device to inform policyholders of the investment experience of the company and to report the nonforfeiture values of their policies.¹³ Significant differences exist, however, in the valuation of the unit. The dollar value of the CREF accumulation unit varies monthly according to realized and unrealized capital gains and losses and operation expenses.¹⁴ It is computed by dividing the market value of assets allocated to accumulation units by the number of accumulation units outstanding.¹⁵ Dividend earnings during the year are reinvested and apportioned to the contract holders at the end of the fiscal year as additional accumulation units.¹⁶

The dollar value of the accumulation unit in some commercial plans varies monthly according to the investment experience of the company. Company operating expenses are not considered since they are guaranteed. The method of computing the dollar value of each unit in these plans can best be illustrated by the following formula:

$$CUV = PUV [1.000 + (d + c) - e],$$

¹³ In order to assure that the policy will be used to provide retirement benefits, CREF does not allow cash or loan values in its contract. Death benefits and paid-up retirement benefits, however, are allowed in an amount equal to the value of the total number of units accumulated. Like the conventional fixed-dollar annual premium retirement annuity, the variable annuity contract issued by other insurers may be surrendered for its cash value before retirement. It also may provide for the payment of the cash value in event of death before retirement and may include the usual loan provision.

¹⁴ A management contract with the Teachers' Insurance and Annuity Association (TIAA) fixes operation expenses at 4 per cent of premiums. In renegotiation, this rate can be either raised or lowered, thus affecting the value of the accumulation unit. An investment management fee of one-forty-eighth of 1 per cent per month of the mean total assets also is paid by CREF to TIAA.

¹⁵ This, of course, is an oversimplified statement of the CREF valuation formula for the accumulation unit. For a good technical discussion see Robert M. Duncan, “A Retirement System Granting Unit Annuities and Investing in Equities,” *Transactions of the Society of Actuaries* (1952), IV, 332–37.

¹⁶ In some variable annuity plans accumulation units are allocated to policies only from premiums paid, and the variations in their unit value reflect the total investment experience of the company rather than only the realized and unrealized capital gains or losses. This has the practical advantage of playing down capital losses, since dividend and interest earnings can offset these losses. The CREF method, however, has the practical advantage of allowing its participants to experience a more rapid growth in the number of accumulation units to their credit. From the point of view of variable annuity theory, it makes no difference how the value of the accumulation unit is reported. Actually, the concept of the accumulation unit is itself unnecessary, since dollar values could be reported directly rather than through units.

where CUV = current unit value, PUV = previous unit value, d = the net interest and dividends earned per 1.000 at the beginning of the month after allowance for income taxes, c = the net capital gains (or losses) per 1.000 at the beginning of the month after allowing for income taxes and e = investment expenses. In determining the value of the current accumulation unit, the previous unit value is multiplied by the net investment factor for the month. The net investment factor is 1.000 plus the adjusted gross investment rate ($d + c$) less an investment expense allowance. Thus, if capital losses caused the adjusted gross investment rate for the month to be minus 0.01, and the investment expense allowance is .0015, the net investment rate would be minus 0.0115, and the net investment factor 0.9885. If at the beginning of the month the value of the accumulation unit were \$1.00, the value at the beginning of the next month would be $\$1.00 \times 0.9885$, or 98.85 cents. If the adjusted gross investment rate for this next month is 1 per cent, then the net investment rate becomes 0.0085 (assuming the same .0015 investment expense allowance), and the net investment factor 1.0085. The value of the accumulation unit for the following month would then be 99.69 cents.

The Annuity Unit. When the contract holder reaches retirement age, two factors determine his dollar income: (1) the number of annuity units to which he is entitled and (2) the dollar value of each unit. The first factor remains fixed, once annuity pay-out has commenced, but the second continues to fluctuate.

The number of annuity units payable is computed by dividing (a) the current dollar value of the total accumulation units available at retirement by (b) the single premium for a life annuity in a monthly amount equal to the value of one annuity unit at the time the calculation is made. For example, if the total cash value of the annuitant's accumulation units is \$30,000, and each annuity unit is paying \$9 per month at the time, a male annuitant at age 65 would receive a straight life annuity of 22.7 units computed as follows: The single premium for a straight life annuity of \$9 a month beginning at male age 65 is \$1,321.50 (Progressive Annuity Table at $3\frac{1}{2}$ per cent).¹⁷ This figure divided into \$30,000 yields 22.7, which becomes the number of annuity units this annuitant has for the rest of his lifetime.¹⁸ His actual income in any given

¹⁷ When the company guarantees mortality and expenses, it uses conservative mortality and expense assumptions. Since CREF makes no guarantees, its assumptions are less conservative. To guarantee mortality means to pay survivorship benefits at least equal to those produced by a given mortality table. To guarantee expenses means to charge the annuitant no more for expenses than the guaranteed maximum.

¹⁸ Some variable annuity contracts fix the amount of the first monthly payment to the annuitant by reference to what is simply a table of annuity values. Let us suppose that the table shows that \$1,000 present value will provide a male annuitant aged 65 with \$6.81 per month under a straight life annuity. Our annuitant whose accumulation units were worth \$30,000 would be entitled to \$204.30 ($30 \times \6.81); and that would be his first month's payment. If the current value of one annuity unit at that time were \$9, as was assumed above, the \$204.30 would equal $(204.30 \div 9)$ or 22.7 annuity units, and that number would be established as controlling his future payments.

month will be 22.7 times the value of one annuity unit when that month arrives.

The value of an annuity unit, like that of an accumulation unit, initially is set arbitrarily. This value is changed periodically according to the terms of the contract. In 1952 CREF established the initial value of the annuity unit at \$10.¹⁹ The value has been changed on March 15 of each year to reflect changes in the market prices of the investments held by CREF, the dividend rates earned on these investments, the ratio of mortality experienced to mortality expected, and the ratio of expenses incurred to expenses expected.²⁰ The valuation formula for the annuity unit may be analyzed as follows:²¹

$$CA = PA \left(\frac{1 + d' + c'}{1 + d} \right) \left(\frac{1 - q}{1 - q'} \right) \left(\frac{E'}{E} \right),$$

where CA = the current annuity unit value, PA = the previous annuity unit value, d' = investment income in terms of the annual rate, c' = capital gains (or losses) in terms of the annual rate, d = the assumed interest (CREF uses a 4 per cent interest assumption), q = the death rate assumed for the past year (for mortality assumptions CREF uses the annuity table for 1949, projection scale B discussed in Chapter 20), q' = the actual death rate experienced for the past year, E = expenses assumed for the year, and E' = expenses incurred for the year. Thus, for example, if the value of the annuity unit last year was \$11, the dividend received 5 per cent, the capital gain 10 per cent, the death rate assumed 4 per cent, the death rate incurred 6 per cent, and expenses as projected, the current value of the annuity unit would be \$12.42:

$$CA = \$11 \left(\frac{1 + 0.05 + 0.10}{1 + 0.04} \right) \left(\frac{1 - 0.04}{1 - 0.06} \right) (1) \text{ or } \$12.42.$$

The annuitant who holds 10 annuity units would then collect \$124.20 a month for the next twelve months. If during these months CREF earns less than 4 per cent, incurs a net capital loss, and experiences less mortality than projected, the value of the annuity unit for the following year will fall,²² and the annuitant's dollar income will be less than \$124.20 for the following year.

¹⁹ In 1953 the value fell to \$9.46 but rose to \$10.74 in 1954. In 1955, 1956, 1957, 1958, 1959, and 1960 the value was \$14.11, \$18.51, \$16.88, \$16.71, \$22.03, and \$22.18 respectively.

²⁰ CREF contracts to pay TIAA 1 per cent of unit annuity payments as an expense charge. This fee also is subject to change on renegotiation. The investment fee mentioned in fn. 14 is charged only during the accumulation period. The above 1 per cent fee is applicable only during the annuity pay-off period.

²¹ One factor in the CREF operations has been eliminated from this formula for purposes of simplification. Since annuity unit values are changed only once a year, whereas investment results change throughout the year, it is necessary at the end of the year to give effect to the result of having maintained a constant unit value throughout the year (see R. Duncan, *op cit*, pp. 338-39).

²² Of course, a combination of circumstances involving greater dividend earnings than expected, a net capital loss, and greater mortality than expected would either increase or decrease the annuity unit value, depending on the predominating factor or factors.

Unlike CREF, some plans evaluate the annuity unit monthly rather than annually and allow the value to fluctuate only to the extent that the net investment rate deviates from the rate of interest assumed in computing the annuity values. When the annuity unit is valued in this manner, the formula is as follows:

$$CA = PA \left(\frac{1 + d' + c' - e'}{1 + d} \right)^{.23}$$

Note that this formula considers only the net investment experience of the company and does not concern itself with either mortality or expense experience since mortality and expenses are guaranteed by the company. If the assumed rate of interest is 3.5 per cent annually or its monthly equivalent of 0.29 per cent, the value of an "annuity unit" would be determined monthly by multiplying the value of the "annuity unit" at the end of the preceding month by the product of 0.9971 and the net investment factor.²³

Why the Variable Annuity? The variable annuity is aimed at meeting two objectives: (1) to enable the insurance companies to issue annuities under which the amount of income will relate, at least to some extent, to the cost-of-living index, and (2) to give the annuitant an opportunity to share in the expected growth of the economy. Since 1900 the price level in this country has been rising on an average of about 2 per cent a year, and many economists see no reason to assume that this long-run trend will not continue in the future. Deficit financing seems to have been accepted as an approach for checking downward trends in production and employment. Since both major political parties are committed to a policy of full employment, federal budget deficits are likely to continue to exert inflationary pressures on the economy. Other "built-in" inflationary features are strong labor unions and a strong farm bloc. The variable annuity principle assumes that stock prices and the cost of living will move in the same direction, thus giving the annuitant a fairly stable amount of purchasing power. Economic studies, however, indicate that changes in the value of common stocks and changes in the cost of living are not perfectly correlated. The stock market is much more volatile than are price levels. Therefore, even the most avid promoters of the variable annuity principle warn against committing all savings for retirement to variable annuities.

There are at least two drawbacks to the variable annuity, one economic and the other psychological.

The economic objection arises from the fact that the cost of living of any one individual will not necessarily fluctuate directly with the general price level. The general price level is based on averages, while the cost of living of

²³ The code of translation for these symbols is the monthly equivalent of those used in describing the CREF valuation formula. The symbol e' is the monthly investment expenses.

²⁴ The use of the factor 0.9971 allows for the 0.29 per cent monthly equivalent of the 3.5 per cent annual rate assumed in the actuarial computation of the annuity value. The value of the "annuity unit" fluctuates, therefore, only if the net investment factor is greater or less than 0.29 per cent.

any given person is based on his personal expenses, which may not contain, in the same proportion, each of the items used in averaging the cost of living. For instance, the housing cost of a person who purchased a home on a mortgage basis in times of lower prices will not rise exactly with the cost-of-living average, which figures in housing costs at the "going rate." Similarly, the cost of living of an individual who bought a home on a mortgage basis in times of high prices will not drop exactly with the cost-of-living average. Thus the variable annuity, even if it exactly followed the cost-of-living index, could never exactly keep pace with the cost of living of any particular individual. A variable annuitant with heavy fixed-dollar obligations acquired in times of high prices could be left with a serious deficit if his income fell directly with price averages.

The psychological objection to the variable annuity is displayed in the attitude of people toward the fluctuating dollar. A man who invests \$1,000 and gets back \$1,500 over a period when prices rise by more than 50 per cent is far less disturbed than if he had invested \$1,000 and got back only \$800 over a period when prices fell by 25 per cent. In the latter case he would be better off economically; although he would be happier in the former case because he is better adjusted to it psychologically. Since the variable annuity is designed to provide more dollars for retirement income when prices are high, at the risk of reducing the number of dollars when prices are low, it has to overcome this adverse psychological block.²⁵

When all is said and done, the question of whether the variable annuity should be purchased is an individual matter. If the annuitant wishes a guaranteed fixed-dollar income and is willing to accept the risk of decreased purchasing power brought on by inflation, then he will purchase the fixed-dollar annuity. If he does not want to rely on the stability of the dollar and is willing to have his money income fluctuate in the hope that, as a result, his real income will fluctuate less, he will purchase a variable annuity. If he wishes to hedge the situation, he will purchase some of each in the proportion that he feels gives him the greatest security.

In addition to the above types of annuities, one more type is available: the group annuity. Since this form of annuity is discussed in Chapter 14, it need not be developed here.

As stated, the various types of annuities described in this chapter are not mutually exclusive. Every annuity will have characteristics from each class. To illustrate, there can be a single-premium, immediate, joint and last-survivorship, refund, fixed-dollar annuity, or an annual-premium, deferred-life-annuity-no-refund, variable annuity.

Several other types of annuities—or, more exactly, annuity combinations

²⁵ Some unions have had experience similar to what might happen under the variable annuity. They negotiated in their wage contracts a clause tying hourly rates to the Bureau of Labor Statistics' "cost-of-living" index at a time when the index was going up. Early in the 1950's the index dropped, thus cutting wages. The unions then argued that the index must be wrong.

—may be found. In fact, there are at least several companies which will write almost any annuity combination anyone wants. However, the annuities discussed here are those which are relatively standard in the business.

3. USES OF ANNUITIES.

When a man reaches that stage in life when he can no longer earn his living and if he wishes to be financially independent, he must live on earnings he has accumulated from the past. Unless that fund is large enough to provide a sufficient income from interest and dividends alone, it will have to be liquidated to supplement the periodic income. As the principal is reduced, income will decline making it necessary to liquidate the fund at an increasing rate if a steady periodic payment is to be maintained. The fund eventually will expire. If the liquidator expires before the fund, there will be no financial problem. There is, however, a real risk that the fund will expire before the liquidator, leaving an old man without an income. It is the function of the annuity to protect against this risk.

To Fund a Retirement Income. The fundamental purpose of an annuity is to provide a vehicle for the scientific liquidation of capital over the years of retirement. It is to assure a person an income he cannot outlive, an income in excess of that to be derived from investing the cost of the annuity in safe interest-bearing or dividend-yielding securities. The annuity can be used to liquidate an estate created through whole life or endowment insurance contracts, investments in stocks and bonds, savings accounts, real estate, or through the annuity contract itself. So long as there is a fund available for liquidation, the annuity principle is available to liquidate it scientifically. And because of high prices, high taxes, and relatively low *net* yields on safe investments, a number of people are faced with the problem of capital creation, not with the idea of preserving it to pass it along to heirs, but to liquidate it systematically through the annuity principle to finance a livable income for their old age. For example, a young man aged 35 who can save \$50 a month toward his retirement would find that at a liberal 3 per cent *net* return compounded annually after allowances for income taxes and investment expenses, he would have accumulated about \$30,000 at age 65. This amount would yield a retirement income of about \$100 a month assuming a 4 per cent return on the investment fund after retirement. If the \$50 a month were put into an annual premium retirement annuity, the guaranteed income at retirement would be about \$150, an increase of 50 per cent over the direct investment plan. This additional income, of course, would be obtained at the expense of liquidating the investment; but it is assumed that a more comfortable income during the last years of life would be worth the sacrifice of an estate at death.

To Liberate Funds for Immediate Use. Even when a man has amassed a fortune large enough to provide a livable retirement income from investment return alone, he might find a use for the annuity. The substitution of an annuity income for a direct investment income can free some capital without

reducing income. For example, it takes a capital sum of \$100,000 to provide an income of \$4,000 a year at 4 per cent interest. An income of \$4,000 a year, however, can be provided for a man aged 65 by means of a single-premium life annuity for about \$50,000, one-half of the amount needed under the direct investment plan. The substitution of an annuity income for a direct investment income will allow him to free \$50,000 of his capital for a philanthropic contribution; moreover, his income will then be guaranteed for life and will be impossible to lose through default of investment. The one problem, however, is the possibility that inflation might make inroads on the purchasing power of this fixed income, as it will on any other fixed income investment. The variable annuity can be used, however, if the annuitant prefers to reduce the purchasing power risk at the expense of giving up the fixed-dollar guarantees.

Although under an annuity his philanthropic interest will not receive as large a gift as it would were he to pass the total \$100,000 on to it at his death, it will receive the money earlier. Moreover, the annuitant will have the pleasure of seeing his money put to some social good while he is still alive. Most of all, the institution will be absolutely certain of receiving the money, which will not be the case if \$100,000 is left to it as part of a will. Investment default might destroy the capital, and wills often are attacked by relatives. Outright gifts by the individual during his lifetime, however, rarely can be contested.

Similarly, the annuity can release funds otherwise required for present support so they can be used for gifts to children or grandchildren before the death of the donor. The recipients then have the money while young, and the donor will have the satisfaction of seeing his family enjoy the money he has accumulated for them. Also, there may be tax advantages of making living gifts as distinguished from transfers at death.²⁶

Tax Appeals. Because only a part of the annuity payments received each period is subject to income taxation, the annuity has appeal to some investors. In order to determine the amount of annuity income to be reported for federal income tax purposes, an exclusion ratio first must be found. The exclusion ratio is determined by dividing the investment in the contract at the annuity starting date by the expected return under the contract. This "expected return" is based on what the Treasury Department judges to be the life expectancy of the annuitant at the time the annuity begins. It is found by multiplying the annual return by a "multiple" obtained from tables established by Treasury regulation. The exclusion ratio is applied to the total annuity income received during the taxable year. All annuity income in excess of this amount must be included as gross taxable income.

Assume that the investor referred to above purchases the \$4,000 annuity

²⁶ Gift tax rates are lower than estate tax rates, and a liberal amount can be given away tax-free. Also, since the gift tax rates and the estate tax rates are progressive, a taxable gift takes property from high estate tax brackets and places it in lower gift tax brackets. See Chapter 17 for a discussion of estate and gift taxes.

at age 65. How will these payments be taxed? According to the annuity tables put out by the United States Treasury Department, the life expectancy of a male aged 65 is fifteen years. Since this is an annual annuity and the tables are set for a monthly annuity, regulations require that this expectancy factor be adjusted downward by 0.5. This makes the adjusted expectancy period fourteen and one-half years, and the expected return \$58,000 ($14.5 \times \$4,000$). The purchase price of \$50,000 represents 86.2 per cent of the \$58,000 expected return. Therefore 86.2 per cent of each \$4,000 annuity payment is viewed by the Internal Revenue Service as a return of invested capital and 13.8 per cent is considered taxable income. Thus, in the above example only \$552 is reportable as income, whereas the entire \$4,000 is subject to income taxation under the direct investment plan. Where the investor is in high surtax brackets, the annuity can offer a real income tax advantage.

Purchase of the annuity for \$50,000 also reduces the gross estate for estate tax purposes. If the *taxable* estate before the annuity was purchased had a value of \$100,000, the federal estate tax would amount to \$20,700 under present estate tax rates. Since the purchase of the annuity would reduce the taxable estate to \$50,000, such a purchase would also reduce the federal estate tax liability to \$7,000. The resulting tax saving is \$13,700. So, in effect, the investor is able to purchase an annuity worth \$50,000 for \$36,300.

The deferred annuity also has income tax advantages during the period of accumulation. The investment earnings are not reportable as income during the year earned. Instead, they are used to reduce the purchase price of the annuity in calculating the exclusion ratio for income tax purposes at the time of distribution. The effect of this procedure is to postpone the tax until the period of retirement when income is likely to be lower, the retirement credit is available, and the double exemption is allowed.

4. LIMITATIONS OF ANNUITIES.

While annuities have a number of legitimate uses, they are not without their limitations. These limitations tend to reduce their attractiveness to some potential buyers.

Expenditure of Capital. For psychological and sometimes economic reasons, old people do not like to use up their capital in providing themselves with a retirement income. They like to leave some of it behind for their heirs. Some are content to live on an income well below that to which their savings entitles them, in order that they may conserve their estates. They do not accept the annuity as a method of increasing their old age income because the annuity liquidates rather than conserves their assets.

Except in the case of the wealthy, an individual should not be concerned over conserving capital for his self-supporting heirs if, in order to do so, he must subsist on an income below that to which his thriftiness, in saving over the years, entitles him. Elderly people often restrict themselves financially in order to leave something to their heirs, without realizing that the heirs would

much prefer that they enjoy their declining years with the higher income an annuity can offer. Again, the elderly often are so concerned over leaving something for heirs that they become a burden on those heirs for part of their support merely to keep from spending their capital. More than one instance can be found of children who would be better off if their parents would purchase an adequate income through an annuity rather than depend on them for help. Parents can become a burden to the very people for whom they are conserving a relatively insignificant amount of capital.

Nevertheless, the fact that the annuity involves the liquidation of capital must be considered as one of its limitations.

Overemphasis on Retirement Values. The real limitations of the annuity arise out of its misuse or misapplication. Annuities insure against economic losses resulting from old age only. They offer no insurance protection against premature death. Upon death of the annuitant prior to the annuity starting date, beneficiaries receive only whatever cash values the contracts may have had; these usually are only the savings of the annuitant, most often with, but sometimes without, accumulated interest. Unfortunately, the high retirement values obtainable through annuities as contrasted to whole life insurance policies might attract family men who have inadequate life insurance protection. No insurable family man should purchase an annuity until he has adequate life insurance protection for his family.

Entire Risk Not Shifted. In any discussion of the limitations of annuities there must be a clear separation between the fixed-dollar annuity and the variable annuity. Unfortunately, the purchaser of an annuity cannot shift the entire retirement risk to which he is exposed. If he buys the conventional fixed-dollar annuity he assumes the purchasing power risk. Unlike the units used in weights and measures, the dollar has not proved itself to be a dependable measuring tool. The dollar fluctuates in value so widely that it becomes impossible for anyone to determine how many dollars will be needed in the future to cover his retirement income needs. Although the annuity has the advantage of safety in so far as the financial risk is concerned, it leaves its holders miserably exposed to the purchasing power risk. Of course, if price levels decline, the annuitant has gained by accepting this risk. But if price levels rise, the annuitant has lost part of the security which he thought he had purchased.

If, on the other hand, the annuitant purchases the variable annuity, he assumes the financial risk—the risk of adverse investment results. While this risk might well be minimized by the insurance company, through a well-managed diversified investment portfolio, it cannot be eliminated entirely. In addition, even with the purchase of the variable annuity, the annuitant has no definite guarantee of protection against the purchasing power risk, although this risk is minimized.

Recent trends in the purchase of individual annuities reflect the declining interest in annuities on the part of non-group buyers. During the past

several years, when all other segments of the life insurance business were experiencing a major growth, individual annuities declined both in the number in force and the amount of annual income guaranteed. Greater use, however, is being made of the annuity options offered under life insurance policies in the settlement of both cash values and proceeds.

5. SUMMARY.

The annuity is a true form of insurance since it takes advantage of the operation of the law of large numbers and the pooling of risks to create certainty out of uncertainty. The uncertainty guarded against is the peril of living too long; i.e., of outliving personal earning power and capital accumulations. Although there are many types of annuities and annuity combinations, each has its individual function.

The immediate annuity is the type to be purchased by the older individual who has a capital accumulation which is not sufficient to yield an investment income large enough to take care of basic retirement needs.

The deferred annuity may be either annual-premium or single-premium. The annual-premium deferred annuity is suited to an individual whose sole remaining need is protection against old age. The purchaser should have no need for additional premature death protection and must have a reasonably certain, regular income until the age when the annuity benefits are to commence. The single-premium deferred annuity is best suited for the person with no additional protection need who has a large sum of capital to invest and who will not need annuity income until later. A frequent user of the single-premium deferred annuity is the professional athlete whose earnings come in the form of large but irregular purses. It is also a form suitable for the professional man who receives an unusually large fee that is not needed for current living expenses.

The straight life annuity should be used when every dollar of the premium investment must go to build up an income which otherwise would be near or below subsistence levels.

A refund annuity of any type should be used only in cases in which the annuity income available is entirely adequate for the needs of the annuitant and the annuitant wishes the psychological satisfaction of "leaving something" for his or her heirs. It is sometimes used when the annuity income is sufficient and the annuitant is in extremely poor health,²⁷ making the chance of his or her living very long unlikely. It should be used if there are dependent children to be supported from the annuity income, as in the case of an uninsurable family man. It should always be used at younger ages.

The joint and survivor annuity is virtually imperative where there is no other income for the support of any one of two or more persons (most commonly a husband and wife) except the income from the annuity.

The temporary life annuity is usable in the infrequent instances where

²⁷ It is very questionable whether anyone in poor health should buy an annuity.

some other source of income will become available at a certain date in the future, the interim income being supplied from the annuity.

For those who wish some protection against the purchasing power risk, the variable annuity has been introduced.

Constantly, more and more people are reaching the age of retirement; at the same time, high taxes greatly reduce the number of dollars an individual can save. The annuity with its scientific liquidation of principal and its combination with investment return and survivorship benefit is the most effective, private-enterprise solution to the problem of old age income.

QUESTIONS FOR CLASS DISCUSSION

1. Term life insurance policies pay off at death. Straight life annuity contracts pay off until death. Since these contracts are opposites, any developments or changes that will increase the cost of term life insurance will decrease the cost of the straight life annuity. Is this statement true or false? Why?
2. Should a young woman 25 years old buy an immediate life annuity? An immediate refund annuity? Why?
3. Does a retirement annuity as customarily written provide for any real old age insurance during the period of accumulation (before age 65)? During the period after the annuity payments begin (after age 65)?
4. Under what set of family circumstances would you recommend each of the following: (a) immediate annuity, (b) joint and last-survivorship annuity, (c) joint annuity, (d) temporary life annuity, and (e) annuity certain?
5. Under what set of conditions would you advise a young family man against the purchase of an annuity?
6. Why does an immediate annuity purchased at age 65 for a given amount of money yield a larger periodic income than a capital fund of an equal amount directly invested in direct conservative securities?
7. How is the variable annuity supposed to offset one of the principal drawbacks of conventional annuities? What are the major criticisms of the variable annuity?
8. Why do annuities cost more today than several decades ago?
9. Would a capable investor ever seriously consider buying an annuity for himself?
10. Explain why a cash refund annuity costs more than an installment refund annuity.

CHAPTER 6

Special Policy Combinations

While functionally there are only three types of life insurance policies (term, whole life, and endowment), these basic forms can be combined in a variety of ways to produce what are called here special policy combinations.¹

Almost every life insurance company has several such combination policies in its rate book. Some are constructed to meet a particular type of life insurance situation. Others may be offered for competitive reasons, being specifically designed for sales appeal or to confuse any efforts at comparison, or both. To attempt to discuss this latter type of special policy combination is beyond the scope of this book; there are literally hundreds of them. However, an understanding of them and their use in any given insurance situation involves breaking them into their component parts—which will always be some combination of term, whole life, or endowment, plus, occasionally, annuity elements.

This chapter discusses those special policy combinations which are more or less common, and are issued by a number of companies in a roughly standardized form.

1. SPECIAL ADULT POLICIES.

Family Income. One of the most widely offered special policy combinations is family income. It is a combination of a basic policy plus monthly decreasing term.² The amount of the decreasing term is always sufficient to pay a monthly income of a stated amount from the death of the insured to a fixed future date. The family income portion of such policies is written for a given period of time, usually ten, fifteen, or twenty years. If death occurs prior to the end of the stated period, the policy pays a monthly income, usually expressed in terms of a percentage of the face amount of the basic policy to which the decreasing term is attached. Originally, a monthly income of 1 per

¹ The annuity is not, of course, life insurance but a reverse application of the life insurance principle.

² It may be offered as one policy or as a combination of a basic policy plus a decreasing term rider. The latter form is probably more common. Usually the rider may be attached to any permanent policy form of longer premium payment duration than the decreasing term. Some companies will allow the attachment of the rider to a level term form of longer duration than the decreasing term. When family income is written as one policy, the basic insurance is usually continuous-premium whole life or some practical equivalent such as paid-up at 85.

cent was almost standard: each \$1,000 of basic coverage meant \$10 of monthly income. Today, however, many companies offer 2 per cent, 3 per cent, or even 5 per cent monthly incomes. Thus with each \$1,000 of face amount, \$20, \$30, or even \$50 a month of income can be arranged during the family income period.³

The guaranteed stated monthly income is derived from two sources: (1) the interest income from the proceeds of the basic policy which are held on deposit by the company under the interest-only option, and (2) the proceeds of the decreasing term insurance which are paid by the company under the fixed-amount option. Under this latter settlement option, the company pays principal and interest in equal installments until the proceeds are exhausted. For example, if the basic policy pays $2\frac{1}{2}$ per cent under the interest-only option, the basic policy will yield \$2.06 per month per \$1,000. The rest of the family income per \$1,000 of basic insurance will have to come from the proceeds of the decreasing term insurance.

When the income payments expire, the face amount of the basic policy becomes payable to the beneficiary, either in a lump sum or under one of the income options in the policy. In some policies the beneficiary is given the option to take the basic amount in cash at the death of the insured, but such election will reduce the monthly income.⁴ Many policies also will allow the beneficiary to collect the commutation value of all income together with the basic proceeds at the time of death of the insured.⁵

If the insured outlives the family income period, the decreasing term expires without value, and the premium for it ceases.⁶ The basic policy, however, continues to maturity or expiration.⁷ At the end of the family income period, the insured simply has whatever insurance is offered by the basic form used in the family income policy or plan. Some policies will permit the con-

³ Increasing the monthly income is merely a matter of increasing the amount of the decreasing term involved

⁴ As an example, in one specific \$10,000 basic family income plan with a 1 per cent income clause or rider, if the \$10,000 is taken in a lump sum at the death of the insured, the monthly income will be reduced from \$100 to \$83.50. If, instead of a lump sum, the beneficiary should elect to take the basic proceeds as a monthly income over a fifteen-year period, the total monthly income during the family period would be approximately \$150 a month

⁵ For a typical example: If the insured should die at the end of five years after taking a \$10,000, twenty-year family income plan, the beneficiary who commutes and takes a lump sum will receive \$23,000 instead of \$100 a month for fifteen years and \$10,000 at the end of that time. Usually the policy provides that either withdrawal of the basic sum or commutation of the term portion can be elected by a beneficiary only if the insured has, during his lifetime, given her this right to elect that option or options in the policy.

⁶ For example, in one company, the gross premium per \$1,000 of a ten-year family income plan with a 1 per cent income issued at age 30 is \$25.89 for ten years and \$23.79 thereafter. Many companies place the term portion of the premium on a limited payment basis. Thus, in another company, the gross premium for a ten-year, 1 per cent plan is \$27.36 for eight years and \$24.01 thereafter. In both of these examples, the basic policy is continuous-premium whole life.

⁷ An endowment "matures"; a term policy "expires."

version of the term portion to whole life or endowment coverage some time before expiry. However, the amount that can be converted is restricted to the amount of decreasing term still in force at the conversion date.

Uses of Family Income. The family income plan is designed primarily to produce a high level of income for a moderate cost during the years when the children are growing up. The cost of providing the same income with permanent insurance alone might be prohibitive for some families. In a typical company it takes about \$1,900 of proceeds to produce an income of \$10 a month for twenty years. On a continuous-premium whole life plan this amount of insurance would require an annual non-par.⁸ premium at age 25 of about \$35.⁹ On the other hand, a twenty-year family income rider producing \$10 a month is written by this same company for an annual premium of \$3.24. When 10 units of this rider are combined with a \$10,000 continuous-premium whole life policy to form a family income policy, the company will pay \$100 a month from the date of the death of the insured until the end of twenty years from the date the policy is issued.¹⁰ In addition, it will pay \$10,000 to the beneficiary when the income period expires. If the wife is the beneficiary and she is 45 at the time the family income payments stop, the \$10,000 proceeds of the basic policy will provide her with a lifetime income of \$37.30, or if the fixed-period option is used she can collect about \$60 a month until her Social Security old age benefits start. The cost of this plan according to the rate book being used would be about \$180 a year if issued at age 25. The \$100-a-month, twenty-year income benefit made available by a \$10,000, 1 per cent family income policy could be provided in two other ways: (1) with approximately \$19,000 of continuous-premium whole life,¹¹ which would take a comparable premium

⁸ Non-par is used to simplify the figures. If participating rates are used, it then becomes necessary to point out that dividends can be expected to reduce the premium in future years. Then the question becomes, "Reduce by how much?" and the illustrations get into dividend projections. For purposes of such illustrations here and elsewhere, it can be assumed that a typical non-par rate is about the same as a par rate after dividends. Par advocates will rush to the fore with pages of figures purporting to prove that this assumption is fallacious, however, we have said that the assumption can be made *for the purpose of such illustrations as these*. To those who wish to try to disprove the assumption, we suggest that they go ahead and do so. It would make a worthwhile outside research paper.

⁹ This figure is from the rate book of a company which grades premiums by use of a flat per-policy addition of \$8. The premium per \$1,000 would be just under \$14 exclusive of the flat per-policy addition.

¹⁰ A family income plan issued, say, January 1, 1962, agrees to pay the stated income from date of death to January 1, 1982, if it is a twenty-year plan. A ten-year plan agrees to pay from January 1, 1962, to January 1, 1972. In the case of the particular company whose rates are being used here, the plan also agrees that it will pay at least three years of income if death occurs within three years of date of expiry. Thus, if death should occur in 1981 under the twenty-year plan, the income would be paid until 1984. Also, premiums on this particular family income rider are payable for two years less than the duration of the benefit; premiums for the twenty-year rider are payable for eighteen years; the fifteen-year policy would require premiums for thirteen, and so on.

¹¹ As stated, it takes approximately \$1,900 of proceeds to produce each \$10 of monthly income for twenty years.

of about \$273 a year in the same rate book, or (2) with \$19,000 initial amount of pure twenty-year decreasing term (premiums payable for sixteen years), for which the comparable premium would be only \$76 a year.

The higher premium of the continuous-premium whole life plan is a result of the fact that while it will pay only \$100 a month for twenty years if death occurs in the year of issue, it will pay \$104.31 to the end of a twenty-year period from date of issue if death does not occur until the second year, \$178.41 if it does not occur until the tenth year, \$336.30 if not until the fifteenth, and \$1,600.56 if it does not occur until the nineteenth year! Further, the cash value at age 65 will be \$11,115, which will pay a man about \$40 a month for life, whereas the cash value under the family income plan basic policy will amount to only \$5,849.40, which will pay a life income¹² of only \$21.

The lower premium of the pure decreasing term method (as contrasted to the family income method) of providing income for the months between the date of the insured's death and the end of the twenty-year period from the date the policy is issued results from the fact that no permanent insurance is involved. Thus all cash and loan values are eliminated. It will not be possible to borrow on the policy even to meet the premium, and there will be no cash value at 65 for retirement. Also no lump sum payment is made to the beneficiary at the end of the income period, and if the insured survives the income period, he also outlives his insurance. He has no more insurance protection from the contract.

The family income policy is used sometimes for mortgage insurance. It is particularly applicable in cases in which the mortgage does not allow prepayment to maturity and cannot, therefore, be paid off with a lump sum benefit from life insurance proceeds. The family income policy will furnish monthly income to meet the mortgage installments as they fall due and provide cash or income after the mortgage is paid off to continue the payment of such house-owning expenses as taxes, insurance, and maintenance.

Limitations of the Family Income Policy. The family income policy has two limitations, both of which arise from its moderate cost: (1) If the policyholder can afford to pay more for his family income protection, he will find definite limitations in using the family income policy. (2) If the policyholder finds the premium for the family income policy excessively burdensome, then by its use he might unnecessarily limit the amount of insurance protection he can provide for his family during the crucial child-rearing period.

Thus, the family income policy is incorrectly used if, as is frequently the case, the life insurance need is for both death protection and retirement values, and the policyholder can actually afford to pay for sufficient permanent insurance to cover the family period income need. It will be recalled from a previous illustration that for a man aged 25, where the \$100-a-month family income is provided entirely by a continuous-premium whole life policy, cash

¹² Both life incomes quoted here are for 120 months certain and life thereafter.

values at age 65 would be large enough to provide a retirement income of \$40 a month, whereas if the family income policy were used, the cash values at age 65 would be able to provide only \$21 a month, just slightly more than half as much. If the insurance program is deficient in retirement income protection and the policyholder can afford the additional \$90 a year¹³ for full coverage under the whole life plan, then the purchase of the family income policy can be considered improper.

It will be recalled that a man aged 25 can provide insurance protection of \$100 a month over a twenty-year family income period for \$76 a year if he uses pure decreasing term insurance. This amounts to only about 42 per cent of the cost of providing this income with the family income policy. Thus, for the cost of providing \$100-a-month family income protection under a family income policy, about \$237 a month could be provided under a pure decreasing term policy. If the twenty-five-year old policyholder has a severely limited budget for life insurance and he can spend only about \$15 a month for family income protection, he might find it wiser life insurance planning to arrange for a \$237-a-month family income through pure decreasing term insurance rather than restricting the income to \$100 a month as would be necessary if he used the family income policy. Although such a choice would sacrifice cash and loan values as well as the permanent protection offered with the basic portion of the family income policy, such a sacrifice might well be warranted in view of the importance of providing adequate family income protection. Accumulations for retirement can be postponed until the immediate obligations of providing for the family are satisfactorily met.

A compromise between the 1 per cent family income policy and the pure decreasing term policy may be made through the purchase of a 2 per cent, 3 per cent, or even 5 per cent family income policy. The effect, of course, would be to acquire more death protection per premium dollar than that offered under the 1 per cent family income policy without having to sacrifice all cash values and permanent insurance. To provide \$100-a-month family income under a 5 per cent family income policy would involve only \$2,000 of permanent insurance, whereas under a 1 per cent policy the amount of permanent insurance involved would be \$10,000. The greater use of decreasing term insurance in the 5 per cent policy than in the 1 per cent policy accounts for its lower cost per dollar of family income provided. The use of a small amount of permanent insurance in combination with the decreasing term gives the policy at least some cash or loan value.

Family Maintenance Policy. Somewhat akin to the family income policy is what shall be called here the "family maintenance" policy.¹⁴ It consists of a

¹³ Many a person who honestly believes he "can't afford" \$90 a year for life insurance thinks nothing of paying that much *a month* for an automobile for which he has no business need.

¹⁴ Terminology in this area has become much confused by the rise in popularity in the mid-50's of a type of coverage which includes all members of the family as insured persons. This form, to be discussed next, has developed all kinds of names among various

basic policy, usually a permanent form, plus level (instead of decreasing) term, either within the policy itself or attachable as a rider. The term portion will provide income for a stated number of years after the death of the insured, instead of to the end of the stated period, as in family income. To illustrate: Assume a man buys a twenty-year family income policy on January 1, 1962, and dies on January 1, 1972. The income will be paid to his beneficiary, as previously explained, until January 1, 1982. However, if he buys a family maintenance policy on the same date and dies on the same date, his beneficiary will receive the income until, not 1982, but 1992. The family income policy pays income *to a stated date*, family maintenance pays it *for a stated period of time*.

As in the case of family income, the family maintenance policy usually pays a monthly income equal to a percentage of the face amount of the basic policy, 1 per cent being common. The income is a combination of the term, paid out in monthly installments of a fixed amount over, say, twenty years, plus the interest on the basic policy being held for payment at the end of the income period. Much the same rules apply on the types of policies to which family maintenance may be attached (if it is a rider instead of a clause in a policy), conversion of the term portion, commutation, etc. as apply in the case of the family income policy.

Uses of Family Maintenance. The legitimate uses of family maintenance are much more restricted than those of the family income policy, since the years over which an extra income is needed are reduced one by one during the lifetime of the insured. For the most part, their uses are confined to special situations, peculiar to isolated, individual conditions. For instance, the insured might wish to make it possible for his widow to postpone as long as possible the use of the life income settlement option for the payment of the proceeds of his permanent life insurance policies. The longer she can delay the starting date of this option, the higher will be the life income she will receive. If a widow aged 45, for example, could postpone the payment of a life income option for twenty years until she reaches 65, she could increase her monthly annuity income from her life insurance proceeds by \$2.07 per \$1,000. On \$25,000 this would amount to more than \$50 a month.

Limitations of Family Maintenance. The principal limitation of the family maintenance contract is its use of level term to meet what is typically a decreasing need for family protection. Therefore, in the majority of cases, family income is to be preferred over family maintenance. For those who want level term insurance written in combination with permanent insurance, a

companies—"family plan," "family protection," etc., some of which names are closely akin to names sometimes used for the form under discussion here. The American Association of University Teachers of Insurance has a "Commission" at work on the standardization of insurance terminology. It is earnestly hoped that it will some day clear up the confusion of terminology here as well as in many other areas in the field of insurance.

multiple protection policy is available. This policy, as explained later, appears to have greater flexibility than the family maintenance contract.

Family Policy. The family policy (called by various names such as "family plan," "family protection," etc.) offers coverage on all members of the family group in one "package." Usually sold in "units," its simplest form is \$5,000 of permanent insurance, such as continuous-premium whole life on the father, with \$1,000 of term insurance on the mother and on each child. The term insurance on the children may be converted as the children reach a specified age, usually somewhere in the early 20's. If the term insurance is not converted, it expires. The term insurance on the wife usually is written to the husband's age 65. Often it can be converted to a permanent form if the husband predeceases her or when he reaches age 65. The premium for the family policy is determined solely by the age of the husband as long as the wife is within a given number of years of his age, say not more than 12 years younger nor more than 7 years older.¹⁵ If she is older or younger than allowable, the amount of her term coverage will be reduced or increased without change of the "package" premium. Sometimes the package premium is based on the exact ages of both spouses. While there is a premium for children, it is not based on either their ages or their number. Moreover, additional children born to or adopted by the family are automatically covered without an increase in the premium.¹⁶ Family policies have the usual nonforfeiture and dividend options, except that they apply only to the permanent portion of the coverage. Waiver of premium in event of the death or disability of the husband is frequently offered. In event of the death of the wife, the premium may be reduced or it may remain level, with the coverage on the husband being correspondingly increased.

While a package of so much whole life insurance on the husband with one-fifth or one-fourth of that amount written as term insurance on other family members is what might be called the "basic form" of the family policy, innumerable variations have been introduced. Some plans offer permanent insurance on the wife as well as on the husband. Some forms use long-term endowment as the permanent coverage on the husband. It is even possible to find a "package" made up entirely of term insurance. In addition, a number of companies offer the family coverage as a rider, attachable to various types of permanent policies issued on the husband. Many companies also offer a one-parent family policy for use in cases in which the other parent is deceased, divorced, or uninsurable.

¹⁵ This limitation is necessary in order to make cash values comply with legal requirements. Any further explanation would be too technical for this stage of the discussion.

¹⁶ Except for infant mortality, the death rate in the ages covered for children under the family policy, is so low that it has little aggregate effect on the flat rate charged in the policy for children collectively. The "waiting period," usually fifteen days, before coverage becomes effective on a new-born child, eliminates the infant mortality factor.

Uses of the Family Policy. The family policy recognizes that there is a need for insurance, at least for final expenses, on every member of the family, but concentrates the bulk of the protection on the breadwinner. Used properly, it can be an excellent form of coverage for the young or very large family with limited premium money. An important advantage of the family policy is that it allows those parents who insist on insuring the lives of their children an opportunity to do so at the lowest possible cost.¹⁷ Companies as a rule do not write pure term insurance on the lives of children. Frequently, parents are lulled into buying high-premium policies on children, a practice which in many family insurance programs represents an unwise use of premium money. With the children insured under the family policy, fewer mistakes are apt to be made in the purchase of juvenile coverage.

Another use of the family policy is to protect the insurability of the children. This is accomplished through the convertible privilege offered with the term coverage. The insurability of the wife is also protected when needed, since her term insurance is convertible upon the death of her husband or when he reaches age 65 and her coverage would otherwise expire.

Limitations of the Family Policy. The biggest "limitation" of the family policy is that because of its low premium, it tempts families to drop permanent coverage on family members, which they actually can afford, and replace it with the family policy.¹⁸ Another limitation is that ownership of a family policy often lulls a family into thinking it has "an insurance program" and keeps it from adding and planning additional, needed coverage.

While the family policy offers an inexpensive way to insure the lives of the wife and children, it does usually require a basic amount of permanent insurance on the life of the father. The cost of this permanent protection might be prohibitive to a family with a small insurance budget and a large family

¹⁷ The question of the advisability of insuring the lives of children is examined later on in this chapter when special juvenile forms are discussed

¹⁸ Spokesmen for the business do not like to have the fact mentioned, but it is nevertheless true that in the early days of the coverage, which came out in its present form in 1956, the rate of lapsation of existing policies apparently being replaced with the family policy was so high it became necessary for many companies to restrict commissions of agents in cases in which issuance of a family policy was followed shortly by lapse of existing coverage. Unfortunately, this restriction on commissions could be applied only in cases in which the lapsed policy and the new family policy were in the same company. There was—and is—no way of determining whether or not a family policy issued in one company brought about the lapse of an existing policy in another company. A certification by the applicant that he is not lapsing existing insurance to take the new policy—a certification usually required on any application for any form of coverage—means little. If the applicant wants to lapse another policy to take the new one and knows that saying so might keep him from getting the new one, he will simply say that no replacement is involved. The authors have never heard of denial of a claim on grounds that fraud was involved in the fact that the applicant stated he did not intend to replace an existing policy even though the two actions were so simultaneous as to make intent almost a foregone conclusion. It is doubtful that any court would uphold denial of a claim on such a basis (This statement, of course, is subject to all the hazards of any categorical statement!)

income protection need. Such a family might need to put all its available premium dollars into term insurance on the life of the breadwinner, postponing a permanent insurance program until later, when either the family income has increased or the family obligations have decreased.

As in the case of all policies, the limitations of the family policy are the limitations of misuse. However, it may be true that the family policy, like the limited-payment policy and the endowment policy, presents a greater temptation to misuse than some other forms.

Multiple Protection. Multiple protection policies are sometimes called "added protection," "additional protection," or some other special name coined by the issuing company. Multiple protection policies provide a specified amount of insurance until a given age or for some specified period, after which the amount is reduced. For example, one common form is \$2,000 of insurance to age 60 or 65, and \$1,000 thereafter. Another is \$2,000 for ten or twenty years, and \$1,000 thereafter. Multiple protection may be issued either as a policy or as a rider to be attached to some permanent policy form. The most common multiple policy is "double protection," as illustrated above; however, triple and even quadruple protection policies and riders can be found.

In structure, the policy is a permanent policy form (usually continuous-premium whole life) plus an added amount of term for the multiple protection period. For example, double protection to 65 is \$1,000 of, say, continuous-premium whole life plus \$1,000 of term to 65. When multiple protection is written as a rider, the premium drops at the end of the additional protection period to that for the basic policy. When it is written as a single policy, the premium may drop at the end of the multiple protection period, or it may remain level throughout the life of the policy. For example, a \$20,000 double protection policy can be purchased at age 25 in one company for an annual participating premium of about \$345 until age 65, at which time coverage is reduced to \$10,000, and the premium falls to about \$206. In another company this same policy can be purchased at age 25 for a level participating premium of about \$308, which remains in force for the life of the policy and is not reduced when the insurance is cut. Both premium plans are actuarially equivalent.¹⁹ Which premium plan is the more desirable depends upon one's budget and the need for building retirement protection. The higher initial-premium plan will provide higher cash values for retirement, whereas the lower level-premium plan might be more easily budgetable.

Uses of Multiple Protection. The use of the multiple protection policy is the same as that of the family maintenance form: extra protection during a period when it is needed—usually the family period. While the family

¹⁹ In comparing the rate of one multiple protection policy with that of another, it is necessary to be especially careful to find out if the contracts are comparable. Not only do premium plans vary but so also do the types of basic policies. Some might be endowment at 85, whereas others might be continuous-premium whole life. In addition, some might provide the extra protection for a shorter period than others.

maintenance provides extra protection stated in terms of monthly income, the multiple protection plan states this additional protection in terms of extra face amount. In the family maintenance plan the extra protection must be taken at so much a month over a predetermined period,²⁰ whereas the extra protection in the multiple protection plan can be taken under whatever settlement option in the policy is deemed most advantageous in view of the income needs at the time of maturity. For this reason, multiple protection policies are more flexible than the family maintenance policy. The double protection package policy often is slightly cheaper than separate, continuous-premium whole life and term bought independently one of the other. The reason is that the basic policy has an addition to the rate sufficient to cover the major portion of the expenses involved in writing the policy; therefore the added term needs to have but little loading for expenses. In one company the saving at age 25 is \$1.82 per \$1,000 non-par. In another company the saving is \$2.01 per \$1,000 non-par. Therefore, if additional term insurance is needed, multiple protection offers a way of getting it at less than the usual market rates for separate coverages.

Limitations of Multiple Protection. Limitations of the multiple protection policy arise mainly from the fact that it is quite easily misunderstood. Buyers often are attracted by the low premium—low in comparison to the same face amount in the form of continuous-premium whole life. They fail to understand (or remember in later years) that the premium is lower because the whole life policy provides the same amount of protection until death, whenever that may be, whereas the multiple protection policy reduces the amount of protection by half or more at the end of some period, such as twenty years, or upon the attainment of some age, such as 65. Moreover, a whole life policy for a face amount equal to the original face amount of multiple protection will provide much higher cash values throughout the life of the policy. This may be particularly important if, at age 65, the policyholder wants to use cash values for retirement income.

The fact that the multiple protection policy provides level term rather than decreasing term can be a disadvantage of the policy when it is used by families that must struggle to meet the premiums required for the bare minimum amount of insurance necessary to bring the children to maturity. For this type of family, decreasing term appears more realistic. Other things remaining the same, the need for insurance decreases gradually as the children grow older rather than decreasing all at once at some period twenty years or so in the future.

On the other hand, for the family that can afford the higher premium, level insurance has certain clear-cut advantages. As a person grows older, other things are not likely to remain the same. Any number of developments could cause a need for more insurance. He may have additional children. His income

²⁰ Except as the policy may provide for commutation of either the income or the basic policy, and for the use of settlement options.

may increase and along with it his standard of living. This could cause him to re-evaluate the income needs of his family in the event of his death. Also, as he grows older, he may accumulate property which could increase his death tax liability. Finally, inflation might reduce the real value of his present insurance, creating a need for additional protection. Many families, therefore, may find that decreasing insurance is far from a realistic solution to their insurance problems.

Mortgage Protection. Any policy purchased with the primary purpose of retiring the mortgage in event of the death of the head of the family is "mortgage protection." Many companies, however, issue a special policy form under the name of "mortgage protection," "mortgage redemption," "home protector," or some such descriptive title. These policies are written on a decreasing term basis for the period of the mortgage. They are arranged so as to provide enough funds to retire the debt if the insured dies before the expiration of the policy. If the policyholder lives to pay off the mortgage himself, the policy expires without value.

The rate for the special mortgage protection policy, as for all decreasing term policies, is low. For instance, for a twenty-year, sixteen-pay participating policy issued at age 25, one company charges \$6.01 per \$1,000 of initial amount. The annual cost of protecting a reducing \$16,000, twenty-year mortgage under this plan is \$96.16, payable for sixteen years. If the policyholder dies before the mortgage is paid off, the policy will pay approximately the amount necessary to retire the mortgage. For example, if the insured dies immediately, it will pay \$16,000. If he dies in ten years, it will pay about \$10,000. If death occurs at the end of fifteen years, the policy will pay only about \$5,600, but this will still be enough to pay off the debt and retire the mortgage.

A popular mortgage protection policy written by some companies combines reducing term with continuous-premium whole life, and is usually written on a level-premium basis. The characteristics of this type of policy vary among companies. Some are written in units of \$5,000, decreasing to \$1,500 of permanent insurance at the end of the mortgage period. Others are written in \$4,000 units decreasing to \$1,000 permanent.²¹ The purpose of the permanent insurance is to provide a margin for insurance, taxes, repairs, and upkeep associated with the property. The policy is designed so that the sum payable at death always will be in excess of the mortgage in order to allow a margin for these expenses. The policy is designed to pay for housing cost, not just to retire the mortgage.

Uses of the Mortgage Protection Policy. The uses of the mortgage protec-

²¹ One company issues a plan that gives paid-up insurance at the end of the mortgage period for the amount of the premiums paid. This seems to be a contract designed to offer sales appeal rather than to meet any particular need. The typical person who needs mortgage protection insurance probably needs the maximum possible insurance protection on his life and therefore should not have any of his premiums going to pay for a limited payment policy.

tion policy are obvious. It is a special policy, designed for one purpose: to retire the mortgage upon the death of the breadwinner.

Limitations of Mortgage Protection Policies. If the policy does not permit installment settlement of the proceeds, it will not fit the situation in which the loan contract does not allow prepayment to maturity.²² Further, the pure mortgage protection policy provides nothing for home maintenance. It is common to think that when the mortgage is paid off, one may live in a house "free." However, taxes, property insurance, and repairs continue—and usually amount to a substantial sum by the end of a year. Provision for these continuing expenses should be made elsewhere in the life insurance program, of course; but too often the mortgage protection policyholder thinks of that policy as providing his family with a house "free and clear" in event of his death. Finally, the mortgage protection policy creates no permanent values; and while the policyholder might say he understands this at the time he purchases the policy, too often when the years have gone by and the mortgage is finally paid off, he experiences a distinct shock to realize his insurance is gone, too.²³

If a family man has reasonably adequate life insurance protection in other policy forms and a very limited additional number of dollars he can put into mortgage insurance premiums, the mortgage protection policy is his "best buy."

Modified Life. A modified life contract is a continuous-premium whole life contract under which premiums are redistributed in such a way that they are lower than average during the first three or five years and higher than average thereafter.²⁴ The premium for a "modified five"²⁵ may be constructed so that it doubles at the end of the first five years. For example, one company's rate at age 25 is \$11.32 for the first five years and \$22.64 thereafter. In another, it is \$12.11 for the first five years and \$24.22 thereafter. All companies, however, do not redistribute their premiums in this way. A company may prefer to charge a little higher premium in the beginning so that the increase at the end of the five years will not be so large. As an example of this type of premium distribution, one company charges \$13.31 for the first five years and \$19.79 thereafter.

Variations also exist among the premium distribution formulas used with

²² The insured should check the provisions of his mortgage in regard to prepayment before buying mortgage insurance. If prepayment is not allowed, or is subject to a prohibitive penalty, the mortgagor should arrange to have his insurance policy settled on an income basis with the payments corresponding to the interval and amount of the mortgage payments.

²³ Actuarially, he has had full value for what premium dollars he has spent, but the question is one of human reactions, not actuarial values.

²⁴ A variation of the modified life may be found that consists of an initial period of decreasing term, with the rate increasing annually as a larger proportion of the term each year becomes permanent insurance until, finally, the term has run out entirely and the premium is that for the permanent form alone.

²⁵ That is, lower than the regular rate the first five years.

the "modified three."²⁶ One company charges \$17.24 for the first three years and \$20.28 thereafter; whereas another company charges \$13.72 for the first three and \$21.76 thereafter. The type of formula used by any company in distributing the premium depends on its sales and underwriting philosophy.²⁷

Dividend payments on participating modified life policies offset at least part of the increased premium. For example, the fifth-year dividend on a modified five purchased for \$11.32 is \$2.99. This dividend can be applied to the sixth-year premium, which jumps to \$22.64. The third-year dividend on a typical modified three purchased for \$17.24 is \$3.67. This dividend will more than pay the \$3.04 increase in the fourth-year premium.

Uses of Modified Life. The modified life policy is particularly helpful to the young family man whose protection needs are high but whose income, while insufficient at the present time to meet those needs with continuous-premium whole life insurance, is good enough so that he can afford more than term insurance. Modified life enables him to carry permanent life insurance at less than the rates for continuous-premium whole life for several years until his income increases. The same effect and a lower initial rate could be obtained by the use of convertible term. Psychologically, however, the modified life is a better plan since it overcomes the difficulty most people experience when it comes to converting term. Furthermore, the increase in the rate at the end of the modified period is not so great as the increase required when term is converted.

When a company does not write a modified life contract, it may offer as competition automatically convertible term. The difference between the two policies is simply in rates. The automatic convertible term will have a lower initial rate than the modified life, but will carry a higher rate at conversion. The choice between the two is basically a personal budget problem.

Limitations of Modified Life. Limitations of the modified life policy arise chiefly from the fact that it is always difficult psychologically (and sometimes financially) for the policyholder to increase his premium when the modified coverage of the policy ceases and the premium advances. In the modified five cited as an example, even allowing for the dividends of \$2.99 in the sixth policy year, the rate increases from \$11.32 to \$19.65, an increase of \$8.33 per \$1,000. On a \$10,000 policy, this would be an increase of \$83.30. Many policies are lapsed at the time the premium increases, indicating that the policy is often improperly sold or that the anticipated increase in income to meet the increase in premium did not materialize.

²⁶ That is, premium increasing after three years

²⁷ The initial rate for modified life usually is higher than the initial rate for convertible term for the same period of time. However, the rate for modified life after the modified period will be lower than would be the rate on a continuous-premium whole life policy to which the term would have to be converted for the same insuring effect as obtained under modified life. To illustrate: the gross convertible term rate at 25 in a typical company is about \$8 per year per \$1,000. If it is converted to continuous-premium whole life in three years, the rate per \$1,000 will be about \$24, compared to \$21.76 for the modified life quoted above.

The other limitation of the policy is that cash values are smaller in the earlier years, since they do not grow appreciable until the end of the initial three- or five-year period. For example, a comparison of cash values of a given modified five and a given continuous-premium whole life shows that, at the end of the tenth year, a modified five has a cash value of \$90 per \$1,000 face amount if issued at age 25, whereas the continuous-premium whole life issued at the same age has a cash value of \$131 per \$1,000. This difference, however, decreases as the policies become older, so that by the time the insured reaches 65, the difference in these illustrative contracts will be only \$14 per thousand. The cash value of the continuous-premium whole life at age 65 is \$606, whereas the cash value of the modified five is \$592. Comparisons drawn between other modified fives and continuous-premium whole life contracts, while not yielding identical results, will show related results.

In the final analysis, however, most policies are purchased not to be cashed out, but for death or old age protection. The death protection afforded by the two policies is identical, and the difference in the retirement protection is small; so the cash value limitation argument against modified life is a weak one. Modified life is a good policy for the young man who wants permanent protection but cannot afford it immediately.

Graded-Premium Life. A variation of the modified life is the graded-premium life. In this contract, premiums advance each year for the first few years (usually five) and then remain level throughout the life of the policy. For example, in one company the rate for a graded-premium life issued at age 25 is scheduled as follows: first year, \$8.86; second year, \$11.93; third year, \$15.12; fourth year, \$18.42; fifth year and thereafter, \$21.82. This compares with a continuous premium of \$20.41 if issued level-premium at age 25. The advantages and limitations of the graded-premium life are the same as those of the modified life.

Guaranteed Investment Policy. The "guaranteed investment" or "coupon" policy occasionally is offered by nonparticipating companies in competition with participating companies. Most commonly, it is a variation of the twenty- or twenty-five-pay life policy, to which are attached coupons, redeemable in cash at the end of each policy year. Usually the coupons compare favorably with participating policy dividends, because they are designed to meet dividend competition; but they have a sales advantage over dividends in the fact that they are guaranteed.

Commonly, the first coupon in such a policy is due at the end of the first policy year, contingent upon the payment of the next annual premium. Each coupon attached to the policy will be paid to the insured in cash upon surrender on its due date, provided the insured is then living and provided all current premiums have been paid in full. Unused, matured coupons may be payable on presentation, with compound interest for each full year after their due date. In the event of the death of the insured, matured coupons will be paid the beneficiary in addition to the amount otherwise payable.

The coupon policy places greater emphasis on savings than on protection. The rate per \$1,000 for the coupon policy is simply an amount sufficient to buy the insurance values in the contract, plus an amount which, together with interest, will equal the amount of the guaranteed coupon when they fall due. The interest rate paid on the additional premium usually is in excess of that obtainable through other comparable forms of investment. However, if adequate life insurance protection is not owned, the funds used to purchase coupons could be used more advantageously to purchase additional life insurance, which, in the event of premature death, would far exceed the value of the coupons.

Return of Premium. A return of the premium rider is issued by some companies. Typically, it will provide that in the event of death within an initial number of years, say twenty, the face amount of the policy will be increased by an amount equal to the gross annual premiums paid to date. It is written in connection with policies issued at certain ages only, 18–50, for example. The return of premium rider does not increase the surrender or loan values of the basic contract and often is not issued with policies with annual premiums exceeding some maximum such as \$200.

The cost of this rider is relatively low. For instance, at age 35 a return of premium rider for an endowment at 85 amounts to only about \$3.25 per \$1,000 of insurance. At the end of twenty years, when the rider expires, the premium will be reduced to the gross premium of the basic policy.

In structure, the return of premium is an amount of increasing term insurance which is always equal to the total of premiums paid to that point. For example, during the first policy year, the amount of term insurance in the rider attached to a policy with an annual premium of \$20 will need to be only \$20; during the second policy year, \$40; and so forth.

The rider has the benefit of increasing, at least slightly, the protection on a policyholder's life for a period of years, and that period often corresponds to the time during which he needs every bit of protection possible. However, the family's insurance program might be better balanced if the additional premiums spent for the rider were used to purchase a decreasing term rider instead. The return of premium rider seems to be a sales gimmick designed to make the customer think he is getting something for nothing. With this rider, an agent can prepare net cost illustrations for a given period which will show that the insurance will be free regardless of whether the insured lives or dies.²⁸

Joint Policies. *Joint life* policies are contracts written with more than one person named as the insured. Most commonly, the joint life policy is issued to two persons, with the face amount payable upon the occasion of the first death only. Occasionally, they may be issued payable upon the first death among several persons named as insured.

Last-Survivor policies are a variation of joint life policies. They pay the

²⁸ See Chapter 24 for a discussion of the fallacy of net cost projections.

face amount upon the death of the last of two or more named as the insured. The uses to which these two policies might be put are highly specialized, and they are not widely written. In fact, the demand for them is so small that companies do not normally include them in the rate manuals issued to agents.

Deferred Life Policies. Under the deferred life policy, the company agrees to pay the face amount only if the insured (usually a juvenile) dies after surviving an initial period. The value of such a policy is the preservation of the insurability of the policyholder. An allowance is made in the premium rate for the deferred life policy to reflect the reduced liability of the company. Usually, the only liability the company has if death should occur during the deferred period is a return of premiums plus interest. It follows naturally that the longer the deferred period, the lower the rate at any given age. During the period of deferral, the deferred life policy is, then, principally insurance against becoming uninsurable. This policy is not widely issued outside Europe.

Guaranteed Insurability. A relatively new policy rider that achieves the same effect as the deferred life policy has become quite widespread in the United States and Canada in recent years. Given various names, its most descriptive is "guaranteed insurability." Added to a basic policy, it provides that the insured may, at various stated times or ages in the future, purchase fractions or multiples of the face amount of the basic policy without evidence of insurability. Maximum additional amounts are usually set, both at each purchase period and in the aggregate.

The coverage requires an additional premium set to develop a company reserve fund in an amount estimated²⁹ to equal the extra premium above standards rates that will be needed for those in the group taking the rider who become uninsurable or extra-premium risks before taking all the additional coverage guaranteed by the rider.

The plan has the advantage of allowing a young man who has not yet fully developed a family to postpone the purchase of some of his life insurance until he needs it without having to run the risk of becoming uninsurable.

Reversionary or Survivorship Policy. The reversionary or survivorship policy (often called a survivorship annuity) has a named insured and a named beneficiary. If the beneficiary survives the insured, he or she receives the proceeds of the policy as a life income. However, if the insured outlives the beneficiary, the policy expires without cash values or other benefits.

This type of policy offers a young person an inexpensive way to provide an income for an older beneficiary. In effect, the reversionary or survivorship policy is decreasing term insurance to the date of the death of the beneficiary. The rate is based upon both the age of the insured and the age of the benefi-

²⁹ "Estimated" is the correct word here. As this is written, no morbidity (rate of disability) tables exist that show, as accurately as mortality tables show the incidence of death, how many of those taking the rider will become extra-premium risks before exercising their purchase options.

ciary and is on a level-premium basis. When written with a young insured and an old beneficiary, the cost is extremely low, since the beneficiary is likely to die before the insured. For example, for a premium of \$95 a year a 30-year-old man could arrange to have an income of \$100 a month paid to his 60-year-old mother should he predecease her. A one-year renewable term policy taken for this same purpose would take an initial premium of more than \$100.

The survivorship policy is not widely written.

2. JUVENILE POLICIES.

Juvenile life insurance is insurance written on the lives of children, usually those under age fifteen. Ages classed as "juvenile" vary from company to company, commonly running from zero through 9 or zero through 14. There are a few cases of juvenile policies running from zero to 4 and from zero to 15. In the last decade, juvenile insurance has witnessed a wide growth in this country.

Because the insured under a juvenile policy is a minor, the applicant is an adult—usually, of course, a parent—in whom control of the policy is vested. This control is conferred either (1) by making the applicant the absolute owner of the policy or (2) by use of a special provision conferring control on the applicant during his or her lifetime and on the insured at the death of the applicant or upon prior release of control by the applicant. The special control provision is generally preferred.

Plans Available. Juvenile insurance is usually issued on one of the following plans: Life paid up at 65; twenty-pay life; thirty-pay life; twenty-year endowment; endowment at 85; twenty-pay endowment at 85; endowment at ages 16, 17, 18, 19, 20, 21. Provisions for installment payment (settlement options) of benefits are commonly available at policy maturity.

It was once common to "grade" (reduce) death benefits in juvenile policies under age 5. Table 8 shows a typical graded death benefit plan. However, more recently the trend has been to "full-benefit-from-age-0" policies.

TABLE 8.

Graded Death Benefits per \$1,000 of Ultimate Face Value

<i>Age at Issue, Nearest Birthday</i>	<i>1st Year</i>	<i>2nd Year</i>	<i>3rd Year</i>	<i>4th Year</i>	<i>5th Year</i>
0	\$ 100	\$ 200	\$ 400	\$ 600	\$ 800
1	200	400	600	800	1,000
2	400	600	800	1,000	
3	600	800	1,000		
4	800	1,000			
5	1,000				

"Jumping Juvenile." A type of juvenile policy which has been gaining in popularity in relatively recent years is known in the trade as "jumping

juvenile." It is called "junior estate builder," "junior accumulator," "guaranteed estate," or some other name by the various companies issuing it. In its most common form it is sold in "units" which provide \$1,000 of protection to some age such as 21, automatically increasing to \$5,000 at that time with no evidence of insurability and with no increase in premium. The continuous-premium whole life rate for this policy issued by one company on a participating basis is \$45.12 at age 1. If issued at age 7, the premium is \$53.63. These premiums compare with \$11.30 and \$11.95 for a level \$1,000 of continuous-premium whole life at the ages indicated. Thus for \$5,000 level protection, the premium would be \$56.50 and \$59.75 respectively. The cash values on the jumping juvenile are higher than those on \$5,000 level continuous-premium whole life. For example, at the end of fifteen years, the respective cash values are \$577.09 and \$470.15. At the end of twenty years the cash values are \$830.27 and \$687.50. Beyond the twentieth year, the difference in the cash values begins to narrow, since the protection under the jumping juvenile increases to \$5,000 without a corresponding increase in premium.

The basic policy is usually endowment at 65, life paid up at 65, or continuous-premium whole life. Its purpose is to protect the insurability of the child, provide protection for the parents against expenses resulting from the death of the child prior to 21, and give the young man or woman a larger amount of insurance coverage at the age when the need for it will be greater by reason of increased (or soon to be increased) responsibilities.

Uses of Juvenile. Aside from the establishment of a fund to pay the cost of final illness and burial, the most common use of juvenile insurance is to provide a college education. For that reason, there will usually be found in the rate book of any company issuing juvenile insurance a number of endowment policies for various periods of years or to specified ages.

The juvenile policy has the advantage of starting a permanent insurance program for a child at a low premium rate. For instance, a nonparticipating, continuous-premium endowment at age 85 (for all practical purposes, a whole life policy) is \$12 per \$1,000 when taken under age six months, in contrast to \$17.30 per \$1,000 in the same company at age 25.

The juvenile policy also makes it possible for an individual to have at least part of his life insurance policies paid up at a relatively early age. For example, a twenty-pay endowment at 85, issued when the insured is under six months, will cost \$21.33 per \$1,000 and will give the insured \$1,000 of paid-up insurance before he reaches 21. Another advantage of juvenile insurance is psychological. If a father encourages his child to pay part of the premiums out of a spending allowance, he may help develop a sense of financial responsibility that the child may carry on through life. Some juvenile insurance is purchased with this motive.

Perhaps the biggest advantage of juvenile is that it makes certain the child will always have some life insurance even if he later becomes uninsurable.

In Chapter 17 attention will be given to another important use of the juvenile policy: its use as a gift medium to implement estate plans.

The Disadvantage of Juvenile. Juvenile insurance often absorbs premium dollars which should be used for protection on the life of a parent. In theory, at least, most companies will not consider an application for juvenile (except under special circumstances, such as the uninsurability of the father) unless a "substantial" amount of insurance is carried by that parent himself. However, the rate book of one conservative company defines "substantial" as an amount "at least twice the ultimate amount of insurance in force and applied for on the lives of all of the father's children." This would seem to mean that a parent with only \$2,000 in force on his own life could apply for and receive \$1,000 on the life of a child. It is hard to conceive of any case in which \$2,000 on the life of the father is adequate protection for his family. The death of a child will cause hardship in many families, and for at least that reason there should be insurance on the life of the child; yet it does seem that the death of the child would cause far less hardship than would the death of the father.

The so-called college fund endowment policy is particularly dangerous. The premium for an endowment at age 18 on the life of a child under six months is \$53.88 gross per \$1,000 in a typical company. It would take a premium of over \$400 a year to provide an \$8,000 fund for college education, a sum that can take a large cut out of a family's insurance budget. When it is considered further that it takes almost \$18,000 of life insurance to provide \$100 a month income to a beneficiary for a period of eighteen years (the time necessary to bring that same child from age zero to college), it can readily be seen how expensive it may be to invest money in juvenile endowments for college purposes.

It is fine to provide a college education for a child, but it should be remembered that it takes money for a child to go through grade school and high school before he is eligible for college. The money for that should be provided through insurance before any investment is made in a policy to guarantee a college fund.

Payor Benefits. The payor agreement provides that if the owner of a juvenile policy (usually a parent) dies before the policy anniversary nearest a given age of the insured (usually 21), the company will waive subsequent premiums on the policy up to that age. Some payor agreements also provide for waiver of premium in case of permanent and total disability of the policy owner, or "nominator." When the payor benefit is requested, a medical examination of the nominator, in addition to the one of the insured, is usually required, although under certain circumstances, payor benefits might be issued non-medically.³⁰ Various underwriting rules relating to maximum and minimum ages of the payor, of the insured, and minimum age differences may be

³⁰ That is, without an examination by a physician. See chapter on "Underwriting the Risk" for a more detailed explanation.

applied. The cost of the benefit depends upon the age of the insured, age of the payor, and type of plan. For example, the cost of a payor benefit covering disability and death of the payor issued with a \$1,000 endowment at age 85 is about \$2 when the insured is age 2 and the payor is 33. For an endowment at age 18, the payor benefit would cost about \$3.75.

3. SUMMARY.

Special policy forms and combinations divide into two classes: (1) combinations which are more or less standard among all companies, the most typical example being the family income policy; (2) unique combinations, which are found only in the policy portfolio of one specific company or of a very limited number of companies, and which are usually designed either for salability or to discourage comparison of rates.

For the practical purposes of discussion, there might be added a third class of special policy combinations—those which are written with the supplemental contracts or riders which have been discussed. In this chapter, only the more common special policy combinations have been described.

Disadvantage of Special Policy Forms. The great disadvantage of special policy forms is that they are often entirely inflexible, covering effectively only one certain set of insurable circumstances; but because they are designed for salability and have many unique talking points, the agent will sometimes “push” them in cases in which the insurable needs of the prospect do not exactly fit the policy. In other words, with the special policy combination, there is a greater-than-usual risk that the need will be twisted to fit the policy rather than the policy selected to fit the need.³¹

Advantages of Special Policy Forms. On the other hand, the special policy combination or form will usually fit, more exactly than any of the standard policies, the particular insurance need for which it was created. The more widespread that particular insurable need may be among the public, the less the danger that the policy will be misapplied. The family income policy, for instance, is an almost ideal combination for the man with a young family and a limited number of dollars he can put into life insurance. Since this is a very general life situation, the family income policy is rarely misapplied. In either buying or selling life insurance, the special policy combination must be studied carefully to make sure that its use in a particular situation is a result of the fact that it is the most perfectly adapted life insurance “program” for the insurable situation and not just a sales package with “a lot of talking points.”

The policies described in this chapter are often written under names different from those assigned herein. The names used here are those most commonly accepted.

³¹ It can also be argued with logic that where the special appeal of a special policy form results in a person placing needed additional protection in force even though the special policy does not exactly fit his needs, he is better off than if he had taken nothing at all.

QUESTIONS FOR CLASS DISCUSSION

1. What are the basic elements out of which special policy combinations are constructed? Taking any combination of them, construct a special policy combination you have never heard of and explain to what set of circumstances it might apply.
2. Distinguish among family income, family maintenance, and family policy plans. Under what set of circumstances would you recommend the family policy to the exclusion of the other two?
3. How does the family maintenance policy differ from (1) family income and (2) multiple protection? Under what set of circumstances would you select the family maintenance policy to the exclusion of the other two?
4. What factors should be studied before recommending a mortgage redemption policy?
5. I. M. Young is presented two policies, one an automatic convertible term, the other a modified five. He asks you which he should buy. What should you tell him?
6. Under what family circumstances would you recommend the purchase of life insurance on children?
7. A proud parent is looking at two policies: one is a "jumping juvenile," which increases protection from \$1,000 to \$5,000 at age 21; the other is a regular continuous-premium whole life written for a level \$5,000 throughout life. His child is one year old. How much would you expect the premium difference to be between these contracts? Which one would you recommend? Why?
8. Under what set of circumstances would you recommend "jumping juvenile" rather than a standard policy form plus a guaranteed insurability rider for a boy?
9. Why was the return of the premium rider developed? To whom would you recommend the rider?
10. Describe a life situation for which you would recommend the survivorship policy. Why is the annual premium on this contract low for a given amount of insurance?

CHAPTER 7

*The "Best" Policy*¹

Frequently the authors are asked to give advice as to whether or not a particular policy is a good buy. Not too long before this chapter was written, one of the authors was approached by a student for such advice. One of his fraternity brothers, who is working his way through engineering school by selling life insurance, had offered him a policy. The student had in hand a beautifully decorated proposal form filled out in somewhat illegible handwriting. "The agent," the naive student reported, "said it was the best policy on the market. What about it?"

It took no more than an hour's study of the proposal form to deduce that this was a twenty-pay modified convertible endowment at 65 with triple protection to age 50, a fifteen-year family income rider, nineteen guaranteed coupons, double indemnity in case of death by accidental means, \$100 monthly indemnity for ten years and lifetime waiver of premiums in event of total and permanent disability, a return of premium rider, and a \$50 identification benefit.

"Whether or not this is the 'best' policy on the market would be difficult to say," the student was told. "I will say, however, that without a doubt it is the most nearly complete dictionary of life insurance terms I have ever encountered in one policy. However, before I can advise you as to its purchase, I will need to know whether you are (1) buying insurance or (2) collecting policies. If you are collecting policies, I urge you to buy this one, because it is one of the rarest I have ever seen. I have no doubt but that in years to come, it will become a collectors' item. On the other hand, if you are buying life insurance, then no one can look at a policy and tell you what policy is 'best.' He must, instead, look at you."

Determining the "best" policy for any individual buyer starts, not with an analysis of any given policy, but with an analysis of the buyer. It is necessary, first, to find out what the purchaser wants his insurance to do. Next, it is necessary to guide the buyer in reconsidering whether his decision on what he *wants* his insurance to do is actually what he *needs* to have done. Finally, it is necessary to find out how much he wants to accomplish the objectives set up for his insurance. Oddly enough, it is not nearly so much the size of a man's income that determines how much he budgets for insurance premiums as the intensity of his desire to accomplish his insurance objec-

¹ This chapter is designed to serve as a summary of the preceding four chapters.

tives. The best illustration of this fact is found in the number of young family men who feel that a \$40 *quarterly* life insurance premium would reduce them to starvation level but think nothing of putting twice that much *a month* into installment payments for an automobile. If it were the custom to display one's life insurance as obviously as it is to display one's car, many more men would find a way to meet the premiums for adequate amounts.²

1. THE MEANING OF THE TERM "BEST."

The term "best" has no meaning in and of itself. It has meaning only when it is used in comparisons. Therefore, there is no "best" policy in an absolute sense. A policy can be termed "best" only *when it is compared with other policies which could be applied to the same need.*

It is impossible to say what is the "best" policy until there is an answer to the question, "'Best' for what need?" In purchasing or prescribing life insurance, it should be remembered that the higher the premium rate at any given age, the less premature death protection the policyholder is buying per premium dollar and the more he is putting into savings. If his need is temporary and wholly for premature death protection and not at all for savings, then term is probably the "best" policy. If his need is largely for savings and only partly for premature death protection, then endowment insurance is probably the "best" policy. If he wants to "split the middle," continuous-premium whole life is probably the "best" policy because it provides a fairly large amount of premature death protection per premium dollar without wholly sacrificing savings. If a man's need is for income at retirement age without any death protection at all, then an annuity is the "best" policy. If his need is entirely for savings and not at all for death protection or old age income, then life insurance is not indicated. Instead, the individual in question needs a savings account or an investment portfolio.

It is impossible to say what policy costs the most without knowing when the policyholder will die. The premature death insurance portion of one policy always costs the same as the equivalent insurance portion in any other policy. All are calculated on the same mortality table and at the same interest assumption—at least in any given company.³

² Another of the authors was recently engaged in an argument with a young family man who contended "the government should do something about it" because it is impossible for a young family man to afford adequate income protection for his family. The author ascertained that this man was paying \$900 a year in installments on an automobile for which he had no business use. At his age, that amount of money would purchase almost exactly \$45,000 of continuous-premium whole life with a twenty-year family income rider giving his family \$450 a month income during the dependency of the children after his death throughout the family income period. Informed of this fact, his reply was, "But you just *have* to have an automobile. Everybody has one. Why, what would it look like if you didn't?" To the suggestion that if an automobile were that essential, perhaps "the government should do something about it," his reply was that *that* would be socialism.

³ Because of the possibility of adverse selection, death protection under a term policy generally costs a little more than under a whole life or endowment form.

The difference in premium rates among different policy forms is based on the amount of the investment element (cash value) in each form. The higher the investment element in a policy, the less is the premature death insurance purchased per premium dollar.

If a policyholder outlives his need for the death protection offered in any given policy, then the high-premium form has been the least expensive because less of each of his premium dollars has been spent to pay for the cost of this protection; more has been used to build up his savings fund.

If, on the other hand, a policyholder dies before he has outlived his protection need, then a term policy would have been the least expensive. Virtually all the money his family receives would be from pure insurance proceeds.

One other point should be held in mind:

There may be said to be two types of investments: "current investments" and "terminal investments." Life insurance is a terminal investment. Its investment value is to be judged only in the light of what it does at maturity, at death, or at retirement age—not the current return it pays or its value at a cash-out point short of maturity, death, or retirement.⁴ To compare life insurance with a current investment is to compare unlike things.

2. DETERMINING THE "BEST" POLICY.

Most people buy life insurance for one or more of three basic reasons: (1) to pay the cost of dying and to provide an income for surviving dependents, (2) to provide cash or income for old age, and (3) to utilize the semi-compulsion features of the life insurance plan to build a savings account. In order to determine the best policy for any individual buyer, it is necessary to know which of the three reasons predominates in the given case. The best policy is the one which gives the policyholder what he finally decides he wants, regardless of whether someone else agrees that what the buyer wants is best for him.⁵

All this means that in order to determine the best policy, it is necessary to know what each policy offers in the way of the three basic objectives for buying. Table 9 illustrates what a number of popular policy forms have to offer in terms of each of the three objectives. Since most people think of re-

⁴One of the fallacies of "net cost" illustrations is that they assume the policy is cashed out at a specified date, whereas a life insurance policy is designed to be kept in force until death, maturity, or retirement age. Only when the policy is kept in force as indicated above, and only after the last dollar of benefits has been paid can its true net cost be determined. The fallacy in illustrations comparing the dollar advantage of buying a current investment with that of buying life insurance is that such comparisons are based on hindsight. They assume that the investor has lived or has died (depending on the illustration) at a given point, whereas any given investor at any given point in his life has no idea whether he will die in the next year or live to a ripe old age.

⁵For example, if the prospective insured has a wife and three children and refuses to budget more than \$100 a year for insurance, term might be the most sensible type of policy for him to buy. But if he wants to accumulate a savings fund for an emergency and is interested in having a large fund at age 65 with a minimum of death protection, then the best policy for these objectives is an endowment at age 65 or a retirement income policy.

TABLE 9.

**Death, Savings, and Retirement Values of Popular Policies
Based on Annual Premium Outlay of \$100 Issue Age 25,
Unless Indicated Differently**

(Typical Non-Par Rates Based on CSO 2½%)

<i>Type of Policy</i>	<i>Death Protection</i>	<i>Savings (cash value) End of 20 Yrs.</i>	<i>Cash Value at 65</i>	<i>Monthly Income at 65 (5 yrs) Certain and Life</i>
Yearly renewable term	Age			
	25: \$14,881	0	0	0
	40 11,628			
	50. 6,506			
	60. 3,016			
10-yr renewable and convertible term	Age			
	25. \$10,070	0	0	0
	35. 8,570			
	45: 5,921			
	55 3,038			
Convertible term to 65	\$8,547	\$1,170	0	0
Continuous-premium whole life	6,333	1,678	\$3,781	\$24 61
Whole life paid up 65	5,701	1,755	4,294	27.99
Endowment at 65	4,854	1,820	4,854	31 60
Retirement income at 65 (male)	3,364 *	1,904	5,345	33 64
20-pay life	3,686	2,035	2,779	18 09
20-yr. endowment	2,168	2,168	0	0
Annual-premium deferred annuity	Cash values (during the first 12 years these values will equal premiums paid, thereafter they will be greater.)	2,315	6,460	42.05

* Or the cash value when it exceeds the face amount of insurance.

tiring at 65, that age is used in the table to illustrate retirement values. The twenty-year point has been selected arbitrarily to illustrate savings values, although, of course, in a policy of more than twenty years' duration, the savings fund continues to grow beyond that point.

If Death Protection Is Predominant. If death protection is the all-important reason for buying—to the complete exclusion of any considerations of savings or retirement⁶—then one of the term forms may be the "best" policy. For example, in the above illustration \$100 will purchase, at age 25, \$14,881 yearly renewable term, \$10,070 ten-year renewable and convertible term, and \$8,547 convertible term to age 65. As time elapses, of course, the protection under all of the illustrated forms except the long term will become

⁶ Death protection may be the sole reason for buying when insurance is purchased solely to cover a debt, when the number of dollars available for premiums is so small the buyer must ignore the other needs, or when, because of the fear of inflation, the buyer prefers savings or investment media other than insurance.

less and less. All permanent or endowment forms will give less death protection during the early years when the need is apt to be the greatest.

Term is subject to two limitations. These limitations may or may not be important considerations in any given case. (1) Term insurance eventually expires, and no one can be certain that he will no longer have a protection need upon expiration or that, in case the policy is not convertible, he will be insurable and can replace the policy with a permanent form. (2) Term insurance has no cash values (except in long-term forms) upon which the policyholder can rely to meet premiums in an emergency.

It is possible, of course, to convert most term forms. However, the human tendency is to put off conversion long after it can be afforded and to let the final conversion date expire.

A long term form, such as term to 65, overcomes some of the disadvantages of short term forms. It does have cash values available for premium loans. Because it runs over the whole period of a man's normal working lifetime, he is more likely to find a time when he feels he has enough spare income to convert some (or all) of it to permanent insurance to take care of any continuing death protection needs in later life.⁷ However, term to 65 offers only one of the functions of life insurance: protection against premature death. It does not build values for retirement. A form of term, however, is the best policy if the only purpose for which the insurance is purchased is for protection against premature death.

If the Need Is Savings. A need for death protection to the exclusion of savings or retirement values is one extreme. The other extreme is a need for savings with little need for death protection or retirement values.⁸ If this extreme exists, a relatively short-term endowment policy may be the "best" policy. The term of the endowment policy should be made to correspond with the desired savings period. If, for example, the period is twenty years, then at age 25 a \$100 annual premium will purchase \$2,168 twenty-year death protection and a \$2,168 savings account to be completed in twenty years should the insured survive the endowment period.

The endowment policy is a convenient means of accumulating a fund which will be available to the policyholder at a fixed date in the future.⁹ As a

⁷ This statement may not be as realistic as one would like to assume. In the first place, postponement does not frequently lead to action. In the second place, the insured may wait until the premiums on the converted policy are so high that he does not feel it practical to make the conversion.

⁸ If there is actually *no* need for death protection, then *no* insurance policy is best (unless for some reason the prospective insured needs the semi-compulsion thrift feature which is so often argued to be an important psychological by-product of life insurance). An independent savings or investment fund would appear to be the best solution.

⁹ Any form of permanent insurance (as contrasted to term) also builds a fund available to the policyholder in the future. This fund is the cash value of the policy, of course. The endowment, however, builds the fund faster than does the whole life form and makes payment of it to the policyholder on a stipulated date a major feature of the contract as contrasted to the whole life form wherein payment is an option.

method of saving, the endowment form (as well as any form other than term) has two advantages over other methods of saving. (1) The policyholder has a definite savings schedule laid out for him and is reminded by premium notices to make his "deposits."¹⁰ Further, he suffers some immediate penalty—loss of the insurance protection—if he fails to adhere to the saving schedule. (2) In event of his death prior to maturity, his beneficiaries receive the face of the policy. This gives the savings plan a chance for speculative gain.

Endowment policies have some drawbacks.

In the first place, the protection element in them expires at a fixed date just as in the case of term insurance. There is no way of knowing whether at the time of expiration all need for death protection will have passed.

In the second place, the attraction of a sizable sum of money at a specified date in the future too often leads the buyer to put dollars into the savings portion of the policy that should be going into death protection. This is especially true in the case of young men who are lured into the purchase of endowment policies by the appeal of high cash values. It is often difficult for the young man with no dependents to see that he undoubtedly will have a family protection need within a few short years. If he buys an endowment form he might find that when he needs more death protection than the policy affords, he is committed to as much premium as he can pay.¹¹ Theoretically, he can convert his endowment policy to a lower premium form, but such conversion nearly always requires evidence of insurability, and insurability can disappear overnight. A change in occupation as well as failing health can reduce the degree of insurability.

A third limitation with policies maturing before retirement age is that the money may not be needed at the time it becomes due. A limited-payment endowment at age 65 would enable the policyholder to build his savings during the premium-paying period at a relatively fast pace without requiring him to accept any part of it (interest or principal) at the end of the savings (premium-paying) period. The effect is to allow the insured to postpone (or, in event of death, eliminate) any income tax liability on investment earnings.

One of the limited-payment whole life forms also may be a good contract to use when emphasis is on a savings plan rather than on protection against death or old age. For example, as indicated in Table 9, on a twenty-pay life form, a \$100 annual premium will buy only \$3,686 of death protection and \$2,779 of retirement protection as compared with \$6,333 of death and \$3,781 of old age protection under the continuous-premium form. But at

¹⁰ The quotation marks around "deposits" are in deference to a ruling of the New York insurance department that premium installments are not comparable to bank deposits. However, the word aptly describes what the policyholder is doing, at least insofar as he himself is concerned.

¹¹ Agents are to blame as well as the buyer. Many consider it axiomatic that the young man cannot be sold protection and so talk an endowment form to him as the line of least resistance. In other words, in such cases a conflict arises between salesmanship and professionalism.

the end of twenty years, \$2,035 will have been accumulated in cash values under the twenty-pay contract, whereas only \$1,678 will be available under the continuous-premium policy.

If the Need Is Retirement Income. One of the most common reasons for savings is to build a fund for retirement. If the need is to provide for retirement income to the exclusion of death protection, then the best policy is an annual-premium, deferred annuity with neither death benefits nor cash values.¹² If the need is for some death protection but largely for retirement income protection, then the retirement income policy is the best policy. If there is a moderate need for death protection but retirement values are still the predominant reason for buying, then the endowment at 65 with the right to take the proceeds under income options might be best.

The various retirement forms have the same drawback as all endowments: Too often they are taken before the policyholder's protection needs have actually crystallized. In the program of the typical buyer, retirement income forms should be purchased last, after death protection needs are adequately covered.

If the Need Is for Both Death and Old Age Protection. If the need of the buyer is for relatively large amounts of death protection and reasonable retirement values as well—the need of most persons—then the continuous-premium whole life form is likely to be the best policy. If purchased prior to approximately age 40, the whole life form has a cash value at age 65 of more than half of the face value. Table 10 shows the cash values and amount of income at age 65 for a \$1,000 continuous-premium whole life and a limited-payment whole life according to various ages of entry.

TABLE 10.

Cash and Life Income Values per \$1,000 at Age 65

(CSO 2½%, Life Income Only, Male)

<i>Age of Purchase</i>	<i>Continuous Premium</i>		<i>Paid Up at 65</i>	
	<i>Cash</i>	<i>Monthly Income</i>	<i>Cash</i>	<i>Monthly Income</i>
20	\$628	\$4 21	\$754	\$5.05
25	607	4.07	754	5.05
30	580	3.89	754	5.05
35	547	3.66	754	5.05
40	505	3 38	754	5.05
45	452	3 03	754	5 05
50	382	2.56	754	5 05

The life paid-up at 65 policy, or any policy paid up before age 65 in the above company, will have a cash value of \$754 per \$1,000 and pay \$5.05 a month retirement income, regardless of the client's age at purchase.

¹² If the deferred life annuity is written with death benefits and cash values equal to premiums paid, then its rate is almost as high as for retirement income insurance, especially at older ages. Nevertheless, this is the way most deferred annuities are written.

If the insured wishes to combine in one contract retirement and premature death protection and yet build a sizable savings fund for emergency at a relatively fast pace, a twenty-five- or thirty-pay life might be the answer.

The choice between limited-pay and continuous-premium is obviously dependent on how predominant the retirement or cash value need is compared to the death protection need. The continuous-premium policy provides the most often desired balance between death protection and retirement needs. For that reason, it more nearly fits the need of the average buyer than does any other form.

3. INVESTMENT QUALITIES OF LIFE INSURANCE WHICH MAKE IT A GOOD SAVINGS MEDIUM.

Safety of the dollar value of principal is an important requirement in the investment plans of most people. No financial institution can boast of a better record than the institution of life insurance has compiled during the past half century. Life insurance has earned for itself a reputation for dependable solvency which cannot be successfully challenged.

Liquidity also is a desirable investment quality. Emergencies arise which call for immediate cash. The cash values of life insurance are completely liquid, available to the policyholder within a few hours or a very few days.¹³ Moreover, cash values are known in advance, for they are stated in the contract. It should be understood, however, that the liquidity afforded by an investment through a life insurance contract refers to the amount of its cash and loan value, and not its face amount or even the money invested in the contract.

Avoidance of managerial care when investment is a side line often is desirable. With life insurance, there are no rents to collect, no repairs to look after, no markets to watch, no competition to worry about, no coupons to clip, and no watching to see if bonds are called before maturity.

Freedom from reinvestment is a valuable investment attribute. Reinvestment is conducive to loss of interest, since there is almost always a time lag between the maturity of an investment and the reinvestment of the proceeds and between the receipt of interest or dividends and their reinvestment. Reinvestment also is conducive to dissipation of funds. When an investment matures, or dividends and interest are paid, there may be a temptation to spend at least part of the maturity value or dividends and interest rather than to reinvest them immediately. Further, reinvestment is managerial activity, which already has been labeled as undesirable in some investing plans

A fair return is another requisite of a good investment, and life insurance does yield a fair rate of return on that part of the premium which actually represents pure investment.¹⁴

¹³ Most policies contain a clause permitting deferment of payment of cash or loan values for six months, except for use to pay premiums. This is a precaution resulting from the Great Depression of the 1930's when it appeared there might be a "run" on cash values as there was on many banks. However, in practice, it is not usual for such deferment clauses to be invoked.

¹⁴ The actuarial-minded who object to the concept that any part of the premium

It would appear at first glance that, to find the rate of return on a single-premium life insurance policy (for example), it would be necessary only to find at what rate of interest the premiums will accumulate to the sum of the cash value plus dividends at any given policy duration. However, such a procedure would not give the true rate of return. To find the true rate of return, the present value of the non-par cost of the decreasing amount of insurance at risk each year¹⁵ for the period under consideration must be subtracted from the single premium. The remainder is the effective amount invested in the contract. Once the equivalent investment deposit and the cash value at the end of any given year plus any accumulated dividends are found, then by mathematical formula and interpolation it is possible to calculate the actual rate of return for any given period. For example, what would be the rate of investment return on a \$20,000 single-premium policy issued at age 35 if the policyholder keeps it in force for fifteen years?

The nonparticipating single premium for the amount of the decreasing term insurance involved for the fifteen-year period would amount to \$1,104.¹⁶ In order to determine the actual amount invested in the policy,¹⁷ this amount is subtracted from the single premium of \$10,575, giving a net investment of \$9,471. The value of the investment¹⁸ at the end of fifteen years is \$13,569.¹⁹ The \$9,471 net investment will accumulate to \$13,569 in fifteen years at an interest rate of 2.425 per cent compounded annually. If the contract were held another fifteen years until the insured reaches age 65 (30 years), the rate of return would be 2.978 per cent.

Protection from creditors' claims sometimes is an investment consideration. In many states,²⁰ this protection, under certain conditions, is accorded to proceeds and often to cash values of life insurance policies by law. Also in many states, the payment of life insurance proceeds may be arranged in such a way as to protect against not only the creditors of the insured but also against creditors of the beneficiaries.

Favorable tax treatment is a definite investment consideration, and life

actually represents pure investment are referred to M. A. Linton, "Analysis of the Endowment Premium," *Transactions of the Actuarial Society of America*, Vol. XX, p. 430.

¹⁵ Face value less cash value (or single premium during the earlier years when it is larger than cash value) each year multiplied by the term rates at each successive age—technically, the amount-at-risk is the face amount of the policy less the policy reserve. Cash value or the single premium (whichever is higher) is used in these computations in place of policy reserve for the following reason: from the viewpoint of the policyholder, the amount of insurance he has is, in effect, the difference between what he is worth dead and what he is worth alive insofar as that particular policy is concerned. This explanation applies also to footnote 16.

¹⁶ Figured by applying a non-par yearly renewable term rate to the face of the policy less the cash values (or invested premium, if higher) at each successive age over the fifteen-year period, and discounting them to the present at 2½ per cent. The final result involved forty-five separate computations.

¹⁷ The premium paid less the cost of the actual insurance involved.

¹⁸ The cash value.

¹⁹ Rounded off to even dollars.

²⁰ Cf. Chapter 8.

insurance stands in a favorable position in this regard. Interest earned on and added to cash values is not taxed in the year earned. How the gain is taxed otherwise is indicated in Table 11.

TABLE 11.

Taxation of Interest Accretions on Life Insurance *

<i>Nature of Benefits *</i>	<i>Income Tax Status</i>
Death Benefits	Nontaxable
Endowment proceeds or policy cash values	Taxable only for the amount proceeds or cash values received exceed net premiums paid.

* Cf Chapter 17 for a more complete discussion of this subject

* Taxation of installment proceeds under settlement options is discussed in Chapter 17.

Facility of estate settlement might be a quality desired in an investment. If so, life insurance merits serious consideration. A life insurance estate made payable to named beneficiaries can be settled directly without the time and expense involved in the probate of a will. It can also be made payable to the beneficiary as a life income, giving her the benefit of the investment services of skilled technicians and planned settlements without the expense involved in the creation and administration of a trust. Finally, a beneficiary under a life insurance policy, unlike a devisee under a will or testament, is not subject to the risk of delay or loss resulting from contention. Especially where major philanthropic interests are involved, relatives have been known to attack wills.

When an investment program is initiated to build a fund to provide a retirement income, additions to this fund must be made periodically or the fund will fall short of its goal. An advantage of building the retirement fund through whole life or endowment insurance policies is the opportunity to make use of the protection offered under the waiver-of-premium clause. If the "investor" becomes totally and permanently disabled, his premium "deposits" will be waived. The fund, however, will continue to grow as though the deposits were actually made, thus *protecting* his retirement savings plans *against interruption through disability*.

4. SUMMARY.

The "best" policy is not to be determined by a study of policies themselves. It can be determined only by the objectives of the prospective buyer. The best policy for him is the policy which is best suited to his objectives. His objectives are, theoretically, his *needs*; practically, they are his *wants*. What a man wants is not always what he needs. While the professional principle of life insurance selling calls for doing everything possible to see that a man buys the right kind of insurance to fill important needs, it sometimes comes to a choice between letting him fill his wants or go altogether uninsured.

When the agent meets with a prospect who wants what he wants even

though it is not what he needs, the agent has the choice of refusing to be a party to any other than the most effective "prescription," leaving the prospect uninsured,²¹ or of giving him a less effective prescription on the theory that a partially effective medication is better than no medication at all.

Most people buy life insurance to fill one of three needs: ²² to pay the cost of dying and to provide income for dependents in case of death; income for old age; savings. Income for old age and savings are closely related.

If the cash value in a life insurance policy can be called "savings," then all life insurance policies except term and annuities are made up of a combination of savings and pure insurance. Finding the "best" policy for any need is, therefore, a matter of choosing the one which has most nearly the exact combination of savings and insurance the need requires.

The only way for a buyer to select the "best" policy is for him to make an honest, objective appraisal of his needs—or of the exact combination of savings and protection which constitutes his need. Because self-analysis tends to subjectivity, he will be wise to seek an outside check of his self-evaluation.

The man who is sick can ask the advice of friends—and he often does. If he is wise, however, he asks the advice of an expert: the physician. A man who is seeking a diagnosis of his insurance needs can ask his friends—and often does. If he is wise, he asks the advice of an expert: a competent agent.²³

There are no "good" and "bad" policies, *per se*. Every policy has its use. Any policy can be used incorrectly. It is a "good" policy when it is used for the right need. It is a "bad" policy when used where it does not apply. The "best" policy is determined by a study of the economic situation of a man, not by a study of policy rates, values, and provisions.

The man who learns to study his needs first and policies second is on the way to intelligent life insurance buying.

QUESTIONS FOR CLASS DISCUSSION

1. Explain why no one policy can be called the best policy.
2. For what type of insurance situation would you recommend renewable term insurance? For what type of insurance situation would you recommend twenty-pay life?
3. Why do you suppose that endowment insurance is so often improperly used?

²¹ And there are agents who *will* refuse to sell other than the most effective policy for the need. For instance, the authors know one agent who keeps the equivalent of a full year's income in liquid savings just so he will never be forced by his own financial need into taking an application for other than the "best" policy for the case. Some of his colleagues consider his attitude the height of professionalism; others label it "bull-headedness."

²² There are other reasons for purchasing life insurance aside from these three basic uses. Some of them will be mentioned in Chapters 15, 17, and 18. Among them are insurance for gift purposes, business insurance, estate plans, etc. However, here the discussion is restricted to the primary family needs.

²³ By the time you finish this course, you will have no difficulty in distinguishing a competent agent from the one who is trying to bluff his way into a sale.

4. Life insurance is sometimes proposed for those whose sole buying motive is a vehicle for saving money. Should these people buy life insurance?
5. Should a person who owns a twenty-year endowment change this policy to a continuous-premium whole life if he feels that the latter now is the best policy for him?
6. What information do you need in order to prescribe the best policy for your neighbor?
7. Explain the advantages of using life insurance policies as a vehicle for building a retirement fund. What are the disadvantages?
8. What type of life insurance do you think is best for you today? Is your answer likely to be different if you are asked the question ten years from now?
9. If, after careful study, you decide upon the policy that is best for you, and your life insurance agent says his company does not write that policy and instead offers you one which he thinks is best for you, what should you do? If you are the agent and are asked for a type of policy that your company does not write, what should you do?
10. Do insurance buyers' wants and needs always coincide? Do you think most people buy the best policy? Explain your answers.

CHAPTER 8

Insurance and the Law

The fundamental principle of life insurance is mathematical; its application is financial; and its interpretation is legal. For the layman to understand the life insurance principle, he need not be an actuary; to understand its application to financial problems, he need not be a financier; and to understand its legal ramifications, he need not be a lawyer.

The subject of insurance law covers a vast array of topics. This and the next two chapters are concerned primarily with these topics. The discussion, however, is not intended as a comprehensive survey of insurance law; instead it is directed to the general student of life insurance. It is designed primarily to provide the legal background fundamental to a practical, everyday understanding of policies and the rights and obligations of parties to them.

1. THE POLICY AS A CONTRACT.

The life insurance policy is a legal contract. As such, it is, in general, subject to the law of contracts,¹ although general contract law is often so modified in its application to life insurance as to be almost unrecognizable.²

Since an insurance policy is a contract, its formation is subject to the fulfillment of the requisites of a contract: (1) There must be an offer. (2) The offer must be accepted. (3) There must be a valuable consideration. (4) The parties to the contract must be legally competent to make a contract. (5) The contract must not be against public policy. In addition, there must be no misrepresentation or intentional concealment of material facts. A discussion of each of these conditions as it applies to or operates in life insurance follows.

Offer. Whether the offer is made by (1) the insurance company or (2) the applicant depends upon whether the first premium accompanies the application.

¹ While some few states have contract codes, these codes are only general rules. Much depends on their interpretation. The "law of contracts" is found chiefly in what is known as "case" or "decisional" law, which is made when an appellate court renders a decision. Such decisions have the force of law since they will generally be followed by other courts in rendering decisions.

² Woodruff, in his *Selection of Cases on the Law of Insurance* (1924), inserted the following significant statement in his preface: "What do they know of the law of insurance who only the law of contract know?" He goes on to say that general contract law has "in various instances been badly warped if not broken in order that insurance law may accommodate itself to the 'actuality of facts.'"

An application submitted without the payment of the first premium is not an offer, but rather an invitation to the company to make an offer. In this case the offer is made by the company by approving the application, issuing the policy, and delivering it to the applicant.

If, however, the application is accompanied by the payment of the first premium, the offer is made by the applicant. If a policy other than the one applied for in the application is issued, then the issuance of the altered policy becomes a counter-offer by the company.³

Usually when the application is accompanied by the payment of the first premium, the company issues to the applicant a conditional receipt and by this action makes a conditional offer to insure the applicant if he meets the requirements of insurability established by the company under the plan, at the premium, and for the amount requested.⁴

Acceptance. An offer may be accepted either (1) by delivering the policy or (2) by payment of the first premium. If the offer is made by the applicant by tendering the first premium with his application, and no conditional receipt is issued by the company, the offer is accepted by the company by delivering the policy. If the offer is made by the company either by delivering the policy or by issuing a conditional receipt, the applicant accepts it by paying the first premium.

Although unreasonable delay on the part of the company in processing applications accompanied by the first premium has been held in a few jurisdictions to constitute acceptance, in the majority it is treated as a rejection of the offer.⁵ Some companies state on their conditional receipt that a delay of sixty days, for example, in issuing the policy may be construed as rejection.

Effective Date of the Policy. A few words are now necessary to clarify the position of the parties relating to offer, acceptance, and the effective date of the contract.

When the premium is not paid with the application, the contract is not in full force until the policy is issued and the agent has delivered it and has accepted the first premium, all while the applicant is still in good health. The delivery of the policy is the offer; the payment of the premium constitutes its

³ This situation will occur, for instance, in the case of applicants who because of conditions of health or occupation are not insurable at standard rates. The company may issue the policy with a larger premium than quoted, or it may issue another type of policy.

⁴ The conditional receipt often is referred to as a *binding* receipt. It is binding, however, only if certain conditions are met. The use of the word "if" completely destroys the meaning of the term "binding." See 63 Yale L.J. No. 4, *Comment, Life Insurance Receipts: The Mystery of the Non-Binding Binder*.

⁵ Some courts, while not holding an unreasonable delay as an acceptance, have held the company liable in tort for negligent delay in acting upon the application. This doctrine has been followed in twelve states (Alabama, Idaho, Iowa, Colorado, Kansas, Kentucky, Nebraska, North Carolina, North Dakota, Oklahoma, Washington, and Wisconsin); has been rejected in ten states (Arkansas, Connecticut, Illinois, Indiana, Minnesota, Mississippi, Missouri, Pennsylvania, Texas, and West Virginia); and has not been acted upon in the other twenty-eight states.

acceptance. After both acts are accomplished, the contract is completed and the insurance is in force.

When the premium is paid with the application but no conditional receipt is issued, the contract is not in force until the policy is delivered to the applicant.⁶ The payment of the premium with the application constitutes the offer; the delivery of the policy is its acceptance.⁷ The completion of both acts is necessary before the contract is effective and the insurance can be in force.

What constitutes delivery of a policy has been the subject of dispute among the contracting parties. Must there be actual delivery, or is constructive delivery sufficient? The answer depends largely on the wording of the application. Unless, however, the application makes it absolutely clear that actual delivery is required, the general rule of law is that constructive delivery is enough.⁸ Actual delivery involves the physical transfer of the policy from the insurer into the possession of the insured. Constructive delivery is usually considered to have been effected if the company has intentionally and unconditionally given up control over the policy. Thus, a policy placed in the mail to the applicant constitutes constructive delivery. Also, a policy placed in the mail to the agent by the company has been constructively delivered if the agent is free to deliver it to the applicant without restriction.

Mere possession of a policy does not establish delivery if all conditions have not been filled. For instance, a policy might be left with the applicant for inspection, but his possession of it does not establish delivery if the premium has not been paid.⁹ On the other hand, the policyholder does not have to produce the policy to prove it was delivered. The *right* to possession rather than physical possession is the controlling factor.

When the premium is paid with the application and a conditional receipt is issued, the effective date of the contract depends upon the provisions of the conditional receipt. Three types of receipts are used. Under the *most common*

⁶ The applicant in this case may withdraw his offer any time before acceptance and has a legally enforceable right to a refund of the premium. On the other hand, when a conditional receipt has been issued, the applicant is not legally entitled to a refund of premium should he change his mind before the policy is issued, although in practice companies may grant this refund.

⁷ Whether the issuance of the policy or its delivery to the applicant constitutes acceptance depends largely on the agreement between the insurer and insured. Delivery of a policy is not necessary to its validity or enforceability unless there is an agreement between the contracting parties requiring that delivery be made. However, most life insurance contracts specify delivery as a condition precedent.

⁸ There are decisions to the contrary, holding that delivery is a condition precedent to putting the contract into force and cannot be met by constructive delivery. Conflicting decisions are the normal thing in law and are to be found on nearly every point in this discussion.

⁹ This is commonly done; but it is usual to require a receipt from the applicant which shows the policy has been handed to him for inspection only and not as legal delivery. Such a receipt is probably not a legal necessity if it can be clearly shown he has not fulfilled all the conditions precedent, but it is a wise precaution and will prevent misunderstanding with the beneficiary should the applicant die before he pays the premium.

form, the insurance becomes effective as of the date of the application or medical examination, whichever is the later, provided the applicant is found insurable as of that time. A claim arising after this date will be paid even if the application papers have not yet reached the home office, provided, of course, that the facts on the application and the results of the medical examination are such that the company would have accepted the application had the applicant lived. The payment of claims even though no policy has been issued is by no means rare. Also, if the health of the applicant changes after the medical examination or if other changes in insurability occur, the policy will be issued as long as the applicant was insurable at the time of application or medical examination.

While the advantage to the applicant of this customary form of conditional receipt is clear, not so obvious is the advantage to the company. The cost of processing an application and issuing a policy is not insignificant. If the applicant refuses a policy after these expenses are incurred, there is no way in which the company can be reimbursed. Collection of the premium in advance under a conditional receipt helps to solve the declination problem.

A second type of conditional receipt used by a number of companies is the approval form, which provides coverage beginning with the date the application is approved by the company at its home office. This form does not offer the insured protection for the period from the date of the application until it is approved by the company. The only advantage to the insured that this type of receipt has over no receipt at all is that protection is made available for the period between the approval of the risk and the delivery of the policy.

A third type of receipt is the unconditional binding receipt. Under its terms, the company binds the insurance from the date of the application until the policy is issued or the application is rejected. Companies using this type of receipt place a time limit on the binder, usually from thirty to sixty days. This truly "binding" receipt is the most advantageous to the prospect because he becomes insured from the time the application is filed until it is acted upon, even though the ultimate action is rejection. This form of receipt is not widely used.

Operative Date of the Policy. Interesting questions arise with respect to applications without conditional receipts and those that have been antedated to gain the advantage of lower rates. If the application has one date, the policy another, and delivery still another, let us see which date governs (1) subsequent payment of due premiums, (2) the incontestable period, (3) the suicide period, and (4) the inception of the term under the extended-term, non-forfeiture option.

The policy becomes effective when the offer has been accepted. When no conditional receipt is issued, this will be the actual or constructive delivery date of the contract after the full first premium is paid. The policy, however, is not dated as of the time of delivery, but instead commonly carries the date of the

application, or the date the policy is actually written. In either case, it is a date earlier than the delivery date. The courts generally have held that the policy date, known as the date of issue, determines when premiums are due even though in the absence of a conditional receipt this means less than one full year's protection for the first premium. As for the suicide and incontestable clauses, the operative date also is usually held to be the date on the policy even though, because of antedating, it is earlier than the date protection actually began. Of course, if the clauses themselves state the operative date, then this date is usually held to cover. If the insured fails to pay a premium and the policy is placed on an extended-term basis, the terms begin with the due date of the defaulted premium even though this is earlier than the anniversary of the effective date of the policy.

Consideration. For a contract to be valid, there must be a valuable consideration; i.e., each party must give or promise something of value. In an insurance contract the value exchanged by the insurance company is its promise as defined in the contract.¹⁰ The consideration given by the insured for this promise is the statements made in the application and the payment of the first premium or installment thereof.

Legal Capacity. For an agreement to be binding on *all* parties, the parties involved must have the legal capacity to enter into a contract. With respect to the insurer, if the company is organized and empowered to solicit life and health insurance under the insurance code and under its charter, its capacity to contract in that state is clear.

With respect to the insured, the requirements are the same as for any other contracting party: he must be of legal age and of sound mind. Thus, two problems arise: minors and the mentally incompetent. In the absence of contrary state statutes, contracts made by minors are voidable except for the reasonable value of necessities.¹¹ In the interest of public policy, marriage contracts are made an exception.

The legal majority in most states is 21. In some states the legal age for females is 18. A large number of states, however, have special statutes reducing the legal age for making life insurance contracts. These reduced legal ages range from 14½ to 16 years. In New York, for instance, the legal age for a minor making a contract for insurance on his own life is over 14½ (insurance

¹⁰ As will be noted later, where there is a promise to be performed by one or more parties to the contract, the contract is called *executory* (as distinguished from *executed*); where only one party makes an enforceable promise, the contract is called *unilateral* (as distinguished from *bilateral*); where the performance depends upon the occurrence of some event that may or may not occur, the contract is called *conditional*; and when a party to the contract stands a chance to receive more than he gives, the contract is called *aleatory* (as distinguished from *commutative*). Such are the characteristics of a life insurance contract.

¹¹ A distinction should be made between the terms "void" and "voidable." An agreement which is prohibited by law and held to be an invalid contract is called *void*. If a contract is held to be valid but one party has the right to rescind the contract on the grounds of incompetency, fraud, or duress, the contract is called *voidable*.

age 15). This is in recognition of the fact that, although life insurance is not a necessity, it has important values to the insured and his family, regardless of the legal age requirement.

Because a contract made with an under-age applicant may be held unenforceable if the minor decides to repudiate it at a later date, "reduced-age" statutes protect the insurer rather than the minor insured. A minor is capable of entering into a contract, and it is not illegal to make a contract with a minor. The insurer is bound by the contract as long as the under-age minor wishes to continue it in force. Furthermore, if the under-age minor repudiates his contract, the law will allow him a refund of *all* premiums paid (although a few courts will allow a deduction for the cost of protection received). The practice of issuing an insurance contract on the application of an under-age minor is not infrequent despite the danger of repudiation. No question of legal capacity is involved, however, if the application for insurance on a minor is made by a competent adult.

Insanity or mental incompetence precludes the making of a valid insurance contract if a guardian has been appointed. Such contracts are void. If no guardian has been appointed, a contract made by the insane or incompetent is voidable and is handled in the same manner as are contracts made by minors.¹²

A person who is too intoxicated to understand the nature of the contract he is about to make also does not have the legal capacity to contract.¹³ He may repudiate the contract when he becomes sober.

Public Policy. To be valid, a contract must be for a legal purpose and not contrary to public policy. Although in the early history of the life insurance business, some courts did hold the life insurance policy to be a contract for illegal purposes, today no such question is involved.¹⁴ There are, however, several instances in which insurance contracts will be held to be against public policy. The first of these involves the absence of an insurable interest.

(1) *Insurable Interest.* The applicant for life insurance must have an insurable interest in the life of the person on whose life the policy is to be written. Without an insurable interest, an insurance policy becomes a gambling contract and, as such, is unenforceable at law. Usually the person on whom the insurance is to be issued and the applicant are one and the same. In this case, insurable interest is held to exist without question or to be immaterial to the contract.¹⁵ Furthermore, the insured has the legal right to name anyone he

¹² The standard of mental competence is very low and includes all but the feeble-minded.

¹³ The ability to understand the nature of the transaction in which a person is about to enter is interpreted very broadly; otherwise, most life insurance contracts made by the soberest of men would be voidable.

¹⁴ During the Elizabethan period, life insurance was widely used as a gambling device. By the end of the seventeenth century, several countries had outlawed life insurance but later amended their laws to allow life insurance where a pecuniary interest existed.

¹⁵ Vance, in his work on insurance law, argues that a person does not have an insur-

wishes as his beneficiary without regard to insurable interest.¹⁶ This latter right is guaranteed by statutes in some states and is established by court decisions in others.

However, if the application for the insurance is made by a party other than the subject of the insurance and that applicant is to be the beneficiary under the policy, he must have an insurable interest in that life.¹⁷ An insurable interest is a reasonable expectation of financial benefit from the continued life of the subject or an expectation of loss if the subject dies. For instance, a parent has a clear insurable interest in the life of a minor child, since he is entitled to the services and earnings of that child. A person also has a clear insurable interest in the life of his or her spouse—the wife because of her husband's legal obligation to support her and the husband because of the value of his wife's services. Actually, the relationship between husband and wife carries a sufficient presumption of insurable interest without requiring proof of close financial ties. In several jurisdictions, courts and some statutes have held close ties of blood or marriage sufficient to establish insurable interest, such as ties between brother and sister, parent and child, and even grandparent and grandchild. The court decisions in these cases seem to have based the insurable interest either on a presumptive financial relationship or on *love and affection*. When love and affection have been held to establish an insurable interest, the resulting loss is construed to be an emotional rather than a pecuniary one. Such rulings, however, are in the minority since the majority rule is that in the absence of a pecuniary interest, love and affection, even when backed by family ties, do not establish an insurable interest.

able interest in his own life since, in effect, he does not live to suffer a financial loss by his death. He concludes that the better reasoning is that insurable interest is not material when a person has insured his own life. Patterson, in his *Essentials of Insurance Law*, agrees with this contention.

¹⁶ Regardless of the legal rights possessed by the insured, however, the naming of an unrelated beneficiary for other than a valuable consideration will be looked upon with suspicion by a company's underwriting department as a possible indication of moral hazard and by its legal department as a possible source of litigation over the payment of proceeds.

¹⁷ Aside from the insurance company, three additional parties are involved in an insurance transaction: the *subject*, the *owner*, and the *beneficiary*. The subject is the person upon whose life the insurance is written. He is usually referred to as the insured. The owner is the person who retains all the rights in the policy (technically known as "incidences of ownership"), such as the right to surrender the policy for its cash value, the right to effect a policy loan, the right to receive policy dividends, and the like. The beneficiary is the person who has the right to receive the proceeds of the policy in the event of the death of the subject. When a person insures his own life and names his estate as beneficiary, all three parties are the same person. But when one person applies for a policy on the life of another and names still another as the beneficiary, all three parties are separate and distinct as long as the applicant retains the incidences of ownership. If a person insures his own life, retaining incidences of ownership, and names another as beneficiary, the owner and subject are the same, but the beneficiary is a separate party. If a person insures the life of another, retains the incidences of ownership, and names himself as beneficiary, the owner and beneficiary are the same, but the subject is a different party.

A number of clear-cut examples of insurable interest that do not involve family relationships may be cited. An unsecured creditor has an insurable interest in the life of a debtor.¹⁸ A business has an insurable interest in the life of a key employee or part owner. A surety has an insurable interest in the life of the principal.¹⁹ Anyone being supported by another has an insurable interest in that person's life, and a woman has an insurable interest in the life of her fiancé. These last two illustrations point up the general rule that insurable interest need not be based on an obligation legally enforceable by law or even on a moral obligation. A factual expectation is sufficient.

A general rule is that even though an insurable interest exists, one person may not insure the life of another without his consent. As a matter of practice, insurance companies usually require the subject to sign the application for the policy. New York has a specific statute which rules void all life and health policies procured without the consent of the subject. Certain exceptions are made. For example, a wife may insure the life of her husband without his consent;²⁰ an employer does not have to obtain the consent of his employees in establishing a group insurance program for them; a father does not need the consent of his minor child to effect juvenile insurance.²¹ The *consent* rule is a precautionary measure taken against the moral hazard. If sufficient insurance is taken by an applicant-beneficiary to make the subject worth more to him dead than alive, the subject might be placed in a precarious position even though the applicant-beneficiary has the necessary insurable interest.

It is generally held that the insurable interest need exist only when the policy is purchased. The courts usually do not inquire into the status of the interest as of the time the policy becomes a claim. Thus a business can continue a life insurance policy on the life of a key man or part owner who is no longer associated with the firm or company. A creditor may continue a policy on a debtor after the debt has been paid.²²

The amount of insurable interest is not a matter of concern for the courts.²³ It is invariably held that the life insurance contract is not a contract of indemnity. The beneficiary, therefore, does not have to establish the amount

¹⁸ A creditor who is fully and completely secured in connection with his debt would not seem to have an insurable interest in the life of his debtor.

¹⁹ That is, someone who has guaranteed the performance of another has an insurable interest in the life of the person for whose nonperformance he will be liable.

²⁰ This is an exception in the New York statute. In other jurisdictions courts may require consent.

²¹ In some states statutory limits are placed on the amount of life insurance which a parent may take on a minor child.

²² Some courts have held that, in a debtor-creditor relationship, an insurable interest is required at the time of the death of the insured since for this purpose life insurance is a contract of indemnity. This is a minority view.

²³ It is a matter of concern, however, for the underwriting departments of insurance companies. Underwriters look upon excessive amounts of insurance with suspicion. They are concerned not only with excesses in relation to the amount of insurable interest involved, but also in relation to the ability of the applicant to pay for the coverage.

of his loss. If insurable interest exists at all, it is presumed to be the amount of the policy. The one exception is the case of insurance taken by a creditor upon the life of a debtor. The courts generally require a reasonable relationship between the amount of insurance and the indebtedness. A creditor cannot insure the life of a debtor for, say, \$5,000 when the debt is only \$150. Such a transaction would be viewed as a gambling contract, and therefore against public policy. Courts, however, have upheld policies for as much as \$6,500 when the debt was only \$1,000. The amount of the allowable discrepancy between the amount of the insurance and the amount of the debt is a matter for the court to decide in each disputed case. The courts generally have been liberal in establishing their standards of reasonableness. The amount of insurance in any event should be enough to repay the premiums for the insurance, the interest thereon, and the unpaid balance of the debt.

(2) *Enemy Aliens*. A contract with an enemy alien is held to be against public policy, and hence void. There is no question on that point. However, questions do arise when a contract has been made with an alien friend who later becomes an enemy. Usually the situation makes it impossible for the alien or the company, or both, to carry out the terms of the contract. The disposition of life insurance contracts made under such conditions has been subject to diverse court decisions. In general, it has been held that the policy terminates and the reserve as of the date of failure to comply with its terms (usually to pay the premium) becomes payable to the owner of the policy. The nonforfeiture provisions apply just as in the case of any other lapse. In some cases it has been held that the policy is suspended but may be reinstated later.

(3) *When the Beneficiary Murders the Insured*. Payment of life insurance proceeds to a beneficiary who has murdered the insured is considered against public policy. Where the purpose of the murder was simply to collect the insurance, the court unquestionably will not allow the beneficiary to collect. A man is not entitled to profit by his own wrongdoing. If the murder was not insurance-induced, but, for example, was to gain revenge for the tramping of an ace, again the courts will deny the murdering beneficiary the right to collect. But if the beneficiary should kill the insured in self-defense, or while insane, the courts will award him or her the proceeds of the policy.

Homicides are not always murders; they may be manslaughters—i.e., they may represent the unlawful killing of a human being without malice expressed or implied. The attitude of the courts in manslaughter cases is not unanimous as in murder cases, although the general view is that the beneficiary may collect life insurance proceeds if he commits involuntary manslaughter.²⁴

When the murderer-beneficiary is not allowed to collect the proceeds of

²⁴ Several states have statutes which prevent a beneficiary from collecting proceeds of insurance policies if he unlawfully kills the insured. Patterson suggests, however, that the courts might interpret such statutes to apply to murders only. Cf. Patterson, *Essentials of Insurance Law*, 2nd edition, New York: McGraw-Hill Book Co., 1957, pp. 166-67.

the policy, the proceeds are paid to the estate of the insured. Where the murderer-beneficiary is also an heir to the estate of the insured, some courts have held that the beneficiary may receive all the estate to which he is entitled under the will or laws of descent. Other courts have ruled that the estate is to be divided among the innocent heirs. This latter ruling seems more in line with the spirit of the law.

Finally, when the insurer can prove that the policy was taken with murder in mind, it can have the policy voided on the grounds of concealment. Premiums paid usually are refunded to the estate of the murderer, his heirs, or as otherwise directed by the court.

(4) *When the Insured Is Executed for a Crime.* Although some courts, on the grounds of public policy, have denied the right of a beneficiary to collect the proceeds of a life insurance policy if the subject has been executed for a crime, the general rule is to allow recovery. In most states a constitutional provision requires that no conviction be allowed to work a forfeiture of the estate of the convicted party. On the basis of these provisions, which most courts hold as expressing a public policy, life insurance policies are not held to be defeated if the insured meets his death by execution for a crime; it is felt that the innocent parties (the beneficiaries) should not be penalized for the crime of another person whose life has been insured.

Distinguishing Characteristics of Life Insurance Contracts. Although requiring the same elements that are required by all contracts, the life insurance contract has a number of distinguishing characteristics. It is a contract of *utmost* good faith, an *executory* contract, a *unilateral* contract, a *conditional* contract, a *valued* contract, a contract of *adhesion*, and an *aleatory* contract.

Utmost Good Faith (Uberrimae Fidei). Most contracts are good faith contracts. In the insurance contract, however, each party has the right to depend on the utmost good faith of the other party regarding the nature of the risk to be assumed. Neither "buyer beware" nor "seller beware" has any place in insurance dealings. A level of good faith above that in the usual commercial transaction is required. It is upon this principle that doctrines of warranty, representation, and concealment are based.

A life insurance company does not have to insure all applicants. It can and does select among them. In the process of selection, the company relies in part on information furnished by the applicant. If this information is false or incomplete, the company may be in a position to void the contract by resorting in legal action to the doctrines of *warranty*, *representation*, or *concealment*.

WARRANTY. A warranty in insurance is a statement or condition incorporated in the contract relating to the risk, which the applicant presents as true and upon which it is presumed that the insurer relied in issuing the contract. Marine insurance, the first branch of insurance to develop commercially, evolved the doctrine of warranty as it applies to insurance. The marine underwriter was usually called upon to underwrite a hull and cargo which he had no chance to inspect. In fact, it might be lying in a port 10,000 miles away.

Therefore, he had to depend entirely upon the word of the person seeking the insurance. Hence, all information in the application for the insurance was warranted to be absolutely exact. If it turned out to be untrue in any particular, the insurance was voidable whether the misstatement was intentional or unintentional, material to the loss or immaterial. Literally, if the captain's wife were warranted to be a redhead and she turned out to be a blonde, the policy could be voided. The strict warranty rule still prevails in marine insurance. Thus the materiality of all statements is established in advance by contract and thereby is taken out of the hands of judicial interpretation.

The doctrine of warranty carried over into the field of life insurance in its early days. Answers to questions upon application for coverage had to be literally true, and the policy could be voided for any misstatement, intentional or unintentional, regardless of whether in the opinion of the courts the questions were material or immaterial.

However necessary in the marine field, it early became apparent that the doctrine of warranty was too harsh for life and health insurance. Public opinion, enlightened companies, and, finally, legislation were factors in outlawing the application of the doctrine of warranty to life and health insurance. The effect is to revert to the common law rules of misrepresentation and concealment. This makes it necessary once again to rely upon a jury or the court²⁵ rather than upon a contractual arrangement for the determination of the materiality of misrepresented or concealed facts.

REPRESENTATION A representation in insurance is a statement made to the insurer by the applicant or his representative before the contract is made as an inducement to the formation of the contract. Technically a representation is not a part of the contract. If it were, it would become a warranty. However, state statutes usually declare that representations made in applying for life and health insurance cannot be used as a defense against claims unless they are written and attached to the policy. For this reason, applications in life insurance are made a part of the policy. Representations, therefore, must first become warranties before they can be used by the insurer as a basis for legal action involving misrepresentation. Because warranties are more strictly interpreted than representations, these statutes could well work against the insured even though they were enacted for his protection. To remedy this situation, states either have a statute or prescribe a mandatory policy provision which declares that *in the absence of fraud*, all warranties in life and health insurance contracts are to be interpreted as representations.²⁶

In general, the doctrine of representations holds that a policy is voidable by the insurer in the event of a misrepresentation of a *fact* which is material to the risk; i.e., which would have led the company to deny the insurance or ask for better terms had the matter been correctly stated on the application.²⁷

²⁵ The jury, if evidence is conflicting; the court, if it is not.

²⁶ Fraud is not made an exception to the statute in New York and in several other states.

²⁷ Four states (Kansas, Missouri, Oklahoma, and Rhode Island) restrict misrepresentation even beyond the question of materiality, for they require by statute that before

The general rule is that the policy is voidable even though the misrepresentation is made innocently with no intention to deceive.

It must be held in mind, however, that an honest statement of *opinion*, even though it proves in error, cannot be cause to rescind a contract. Whether a statement is to be interpreted as one of *opinion* or *fact* is up to the court. In a number of cases it is obvious that all the applicant can be expected to give is his opinion. Examples are questions involving ancient family history, contemplated changes in occupation, contemplated trips to foreign lands, and whether he is an excessive drinker. In other cases it is obvious that the applicant is expected to present facts. Examples of these are questions involving the applicant's occupation (past and present), whether he has been refused insurance by other companies, and the amount of life insurance he owns on his life. The less obvious cases are the ones that require the court to sift the evidence carefully. For example, although the applicant's answers to questions about his health usually are a matter of fact, they can under certain circumstances be a matter of opinion.

Another general rule is that a fraudulent misrepresentation of an *immaterial* fact will not provide sufficient grounds for avoidance. The purpose of the doctrine of representation is to protect the insurer. It is not to punish a dishonest insured. If the insurer is not harmed, he should not be allowed to rescind the contract under this doctrine.

CONCEALMENT. Concealment also may be grounds for rescission. A concealment is the failure to disclose a material fact; i.e., remaining silent when there is an obligation to speak. In life insurance, in order to void a policy, a concealment must be both *material* and *intentional*. It is often difficult to distinguish between an intentional and an innocent concealment. The burden of proof that there was fraud is on the company. The test of fraud (intentional deception) usually applied is whether the facts are *obviously* material. If they do not seem obviously material to the judge, the insurer must show him why the insured should have been aware of their materiality.

It is the duty of the applicant to reveal in full all details or information asked for in the application. An incorrect answer is misrepresentation. A partial answer is concealment. Assume that the applicant is asked if he has ever had a pain in the chest, and although he has one at the time the application is being completed, he says, "No." He would be guilty of a misrepresentation. Assume on the other hand that the applicant is asked if he has consulted a physician in the past four years and, if so, for what purpose. He reports that he consulted one for a common cold but fails to report that he has consulted one about the pain in his chest. In this case he would be guilty of concealment. If, after the application is signed, but before the policy is issued,

a contract may be voided, the loss itself must result from the fact misrepresented. In these jurisdictions, death by an automobile accident may require payment of the proceeds of a life insurance policy even though the insured misrepresented his health. This type of statute excuses the court from ruling on materiality and relieves it of the task of achieving expertness in the art of underwriting (risk selection).

changes occur which would alter any of the answers given, the applicant must reveal these changes if they are obviously *material*, otherwise he may be guilty of concealment. Of course, if the first premium has been paid with the application and a conditional receipt issued, a subsequent change in the insurability of the applicant is *not* material to the risk because the company has agreed to accept or reject the application on the basis of the insurability of the applicant at the time the application is made or at the time the medical examination is taken, whichever is later.

As a rule, the applicant has no responsibility to reveal information not asked for on the application, since it is assumed that if it is not asked for it is not important, nor does the applicant have a responsibility to reveal information that can be presumed to be known to the company. Further, if a question on the application is not answered and the policy is issued anyway, the company will be deemed to have waived the requirement for an answer.²⁸

It should be pointed out that while courts seem inclined to lean over backwards in interpreting the doctrines of warranty, representation, and concealment in favor of the policyholder, they are also inclined to take a serious view of palpable fraud. The best advice to the applicant for a life insurance policy is not to rely on the penchant of the courts, and especially juries, for deciding in favor of the individual as against the "soulless corporation," but to answer each question with a clear conscience and reveal any information that he thinks might make a difference.²⁹

An Executory Contract. An executory contract is one in which one or more of the parties to it make a legally enforceable promise to be performed after the contract is made. Where performance is completed by all parties after the contract is made, the contract is called *executed*. By its very nature life insurance is an executory contract.

A Unilateral Contract. A distinction is also drawn between *bilateral* and *unilateral* contracts. In the bilateral contract, each party to the contract makes promises to the other, each in consideration of the promises of the other. In the unilateral contract, only one of the contracting parties makes legally

²⁸ A waiver is generally defined as the intentional relinquishment of a known right. Thus, the company has a right to demand an answer to the question not answered. If it does not, it has intentionally departed from the right to the answer. Closely related to waiver is "estoppel." Estoppel comes about when one party to a contract, by his action or inaction, induces the other to change his position to the disadvantage of the first party. Whereas one court might hold that failure to demand an answer to an unanswered question constituted *waiver* of the right to make the demand, another might hold the company was *estopped* from demanding the answer. Waiver and estoppel are alternative methods of being placed in the same situation. Whether a given result is reached by waiver or estoppel, the result is essentially the same. The dividing line between the two concepts is decidedly blurred.

²⁹ Uniquely among contracts, life insurance and a growing number of health insurance contracts contain clauses rendering them incontestable after a specified period of years, usually one or two. If the misrepresentation or concealment is not discovered by the company prior to the expiration of the period of contestability, it cannot be used to void the policy or as a defense against a claim. The incontestable clause is discussed in the next chapter.

enforceable promises. A life insurance policy is a unilateral contract.³⁰ Only the insurer makes any legally enforceable promises. The insured does not even promise to pay premiums. It is impossible for him to be held for breach of contract. Payment of premiums is merely a condition precedent for the continuation of the promise of the insurer in its present form. Not only is the insurer not able to force the policyholder to pay premiums, but he cannot even void the contract if premiums are not paid. The contract remains in effect as to the nonforfeiture provisions and the right to reinstate.³¹ On the other hand, the insurer is forced to accept premium payments from the insured, and to keep the contract in force in accordance with its terms.

A Conditional Contract. The obligations or promises of the insurer as set forth in the policy contract are conditional; i.e., they are conditioned on the performance of certain acts by the insured or beneficiary. For example, they are conditioned on periodic payment of a stipulated premium, furnishing proofs of death or disability and the like. Performance on the company's part is also conditioned upon death resulting from causes other than certain specific ones that are excluded in the policy, such as suicide (within the suicide period), war (in some cases), or accidents involving certain types of aviation.³²

A Valued Contract. Most property insurance contracts are contracts of indemnity: they agree to pay no more than the amount of the loss the insured has suffered. For instance, a \$10,000 fire insurance policy will not pay \$10,000 for every fire. It will pay only the actual cash value of the damage suffered up to a maximum of \$10,000. Health insurance policies may have some indemnity provisions. For example, they may agree to pay the cost of medical or hospital care, or of surgical procedure up to a maximum limit; but if the actual cost is not the maximum limit, then they will pay only the actual cost. In other of their provisions, such as accidental death, dismemberment, and loss-of-time benefits, health insurance policies are not contracts of indemnity but stated value contracts.

The life insurance policy, however, is never a contract of indemnity. It is an agreement to pay a given sum of money upon the occurrence of a stated contingency (death, or survival in case of endowment). It may also pay additional amounts in event of disability or of death by accidental means, but these, too, are stated values, not indemnities. They do not measure payment by the actual cash value of the loss. Who can place a dollar limit on the value of a life?

Furthermore, the usual physical-damage, property insurance contract

³⁰ The assessment policy is an exception.

³¹ These policy provisions are discussed in Chapter 9.

³² Such restrictions were once much more common. In the earlier days of life insurance in America, policies were often filled with restrictions regarding travel abroad, travel below or above certain latitudes, travel in Indian country, etc. The present-day policy has dropped almost all such prohibitions, the latest, airplane travel, gradually being dropped from more and more policies. Special restrictions such as war clauses come and go, depending on the imminence of war or nearness to a past war.

calls for subrogation to the insurer of any rights or claims he may have against anyone else for indemnification for that same loss.³³ The doctrine of subrogation does not apply in life and health insurance. An injured person (or the dependents of a person killed) may not only collect the benefits of a health (or life) insurance policy, but also may retain any damages the court orders paid by the party whose negligence caused the injury (or death).

A Contract of Adhesion. In some contracts, both parties to it bargain for the terms. In life and disability insurance contracts, no such bargaining is possible.³⁴ The terms are stipulated by the insurer and must be accepted or rejected *in toto* by the applicant.³⁵

Actually, as will become apparent in the next chapter, insurance companies do not have complete control over the terms of the contract. As in a marriage contract, neither party is the sole master of the conditions. Standard provision laws, reduction of warranties to representations, and entire contract statutes have seriously restricted the insurer in drawing up contracts.³⁶

Nevertheless, in life and health insurance, the insurer draws his own contract within the limits of the law. Therefore, since the insured cannot bargain for the terms of the contract, courts hold to the principle that in the case of ambiguity in contract terms, the policy will be strongly construed against the insurer. It is his responsibility to make the terms clear.³⁷

An Aleatory Contract. Most contracts are commutative, i.e., each party gives up in property or services of equivalent monetary values. In the sale of a secondhand textbook, for example, the buyer gets the book and the seller gets its equivalent value in cash. In an aleatory contract there is no mutual exchange of equivalent monetary values in so far as the individual policyholder is concerned.³⁸ The company might pay out far more on behalf of any one policy-

³³ To illustrate: If an automobile on which there is collision coverage is struck by another automobile, the insurer will be obligated to indemnify the owner of the struck car for the loss. When the owner accepts that indemnification from his insurance company, he hands over to it (subrogates) his right to sue the owner of the car which struck him. If the collision company elects to prosecute the claim, and if it subsequently collects, it retains the sum collected up to the amount it paid, turning the excess, if any, over to the policyholder. However, if the passenger in the death seat is killed, his life insurance company is not entitled to subrogation rights against the careless driver. The estate of the deceased may collect both from his insurance company and from the guilty party (or the liability insurance company involved).

³⁴ There is sometimes a chance for a limited amount of bargaining in large health group contracts or in a manuscript policy covering a special health risk.

³⁵ Except as some riders and supplemental agreements may be accepted or rejected without affecting the basic coverage. However, in such cases the rider or supplemental agreement must be accepted or rejected *in toto* with no bargaining for its terms.

³⁶ On occasions when the question as to whether an insurance policy is a contract or a statute (especially with respect to standard policies and provisions) has been put up to the courts, the discussion generally has been circular in nature.

³⁷ There is a moot question in the case of statutory provisions as to whether ambiguities should be interpreted against the companies since the consuming public was in theory represented by the insurance commissioner in drawing up the statutory provisions.

³⁸ This is not to say that the individual policyholder necessarily pays more or less than the actuarial value of the policy or that the company necessarily collects more or less

holder than it receives from him. Likewise, in term insurance, an individual policyholder might never receive a penny from the company. There is an element of chance.

Aleatory contracts may be of several types: gambling, speculative, and insurance. A *gambling* contract is illegal. It creates the risk from which the chance of gain or loss stems. The *speculative* contract is legal. It shifts an existing economic risk from those less prepared to assume it to those more prepared (or willing) to do so. The *insurance* contract, also legal, reduces an existing financial risk in society. The insurer accomplishes this by taking advantage of the law of large numbers to reduce risk by predicting losses. Because the insurer is expected to receive enough in premiums to pay all claims and expenses, its total business is no more aleatory than that of any other business, although it specializes in aleatory contracts.

In Summary. An insurance policy is a legal contract. As such it is subject to the general law of contracts, although in some aspects the law of contracts is so altered when applied to insurance as to be somewhat unrecognizable. For a policy to be valid, it must meet the essentials of all contracts. There must be an offer, acceptance, consideration, and mutual assent. Mutual assent in a policy contract is evidenced by the application signed by the insured and the written policy issued by the insurer. The agreement must be made between parties legally capable of contracting. The objective must not be for an illegal purpose and must not be against public policy. Finally, a life insurance contract has certain special characteristics, most important of which are its unilateral, adhesive, and aleatory nature.

2. CREDITORS' RIGHTS IN LIFE INSURANCE.

The primary purpose of life insurance is to protect the dependent family in the event of the insured's death. If insurance benefits were limited to those who survive a solvent insured, protection for beneficiaries might in some cases be lacking when most needed. Accordingly, the states have enacted statutory provisions exempting the proceeds of life insurance policies from the claims of creditors of the insured. In the words of a New York court, these exemption laws were enacted for

. . . the humane purpose of preserving to the unfortunate or improvident debtor or his family the means of obtaining a livelihood, and preventing them from becoming a charge upon the public.³⁹

The laws vary from state to state.

The rights of creditors in life insurance therefore depend largely upon state statutes, which not only are different in themselves but also are subject to even further variation by the effect of court decisions. Although the exact

from all of its policyholders as a group than it anticipates it needs to conduct its business efficiently.

³⁹ *Crossman Co. v. Ranch*, 263 N.Y. 264, 188 NE, 748.

rights of a creditor in any state can be ascertained only by a close study of the laws and court decisions in the state involved, a general summary may be given under five headings. (1) rights of the insured's creditors in the proceeds of the policy; (2) rights of the beneficiary's creditors in the proceeds; (3) rights of the insured's creditors in the cash values; (4) rights of the beneficiary's creditors in the cash values; (5) rights of creditors where state statutes do not apply.

Rights of the Insured's Creditors in the Proceeds. The rights of a creditor of the insured in the proceeds of a life insurance policy are usually severely restricted.

In some states the entire proceeds may be exempt. In others, there may be a limitation. The statutes in some jurisdictions limit protection to proceeds payable to the insured's wife or children. Others protect proceeds payable to any dependent relative. A number of statutes exempt proceeds payable to any beneficiary other than one who is himself the insured, without regard to relationship or dependency.⁴⁰

Proceeds paid to a trustee for the benefit of a given beneficiary have the same protection from creditors' claims as if they were paid directly to that beneficiary. This rule is well established both by case and by statutory law.

The rights of creditors in disability income benefits payable to the insured are not usually restricted by exemption laws in the same manner as are life insurance proceeds. However, a number of states do grant limited exemption to such benefits, such limit being with variations, either a fixed total amount monthly or a monthly amount equal to that purchased by a maximum annual premium.

Creditors' rights in annuities also are not usually limited by the exemption laws applying to proceeds of a life insurance policy if the purchaser is the annuitant. In the absence of a specific statutory provision, an ordinary annuity may be reached by the creditors of the annuitant.⁴¹ It has also been ruled that a trustee in bankruptcy can reach the annuity income payable to an insured from the cash values of a life insurance policy.⁴² Where a person purchases an annuity for someone else, a number of states have statutes exempting proceeds from creditors' claims.

Rights of the Creditors of the Beneficiary in the Proceeds. Generally, the statutes exempt the proceeds from the claims of the insured's creditors only, although in a few states the law extends to the claims of the beneficiary's creditors as well. If the statute does not extend to the beneficiary's creditors, the insured may make this protection possible by including in the policy settlement agreement a *spendthrift trust clause* which states that the benefits payable to any beneficiary hereunder after the death of the insured shall not be assignable

⁴⁰ Such broad exemption would seem a perversion of the original purpose of such exemptions and not be a protection of dependents but merely a means of avoiding the just claims of creditors. These broad exemptions have been widely criticized.

⁴¹ A few states have statutes which exempt annuity income where the annuitant purchases the policy himself; this exemption may, however, be limited in amount.

⁴² In re *Schaeffer*, U.S.D.C. 189, Fed. 187.

or transferable nor subject to commutation, incumbrance, legal process, execution, garnishment, or attachment proceeding.⁴³ To take advantage of the clause, policy proceeds have to be made payable to the beneficiary under one of the installment settlement options, and the payment arrangement usually has to be set up by the insured. The funds so held by the company for distribution are not attachable when there is a spendthrift trust clause. The clause protects only the money held by the company for the beneficiary. As soon as the beneficiary receives the money, it may be available to her creditors.

More than half the states have statutes recognizing spendthrift trusts. These statutes were enacted (1) because the courts were not recognizing spendthrift trusts, (2) because the courts were recognizing them and there was a desire for some restrictions, or (3) because the situation needed further clarification.

In the majority of those states where no statutes exist, courts have upheld spendthrift trust clauses. This leaves only a few states where these clauses are held to be against public policy and are disallowed. In these states, proceeds may be protected from the claims of the beneficiary by creating a discretionary trust and making the trustee the beneficiary under the policy. Under the discretionary trust, the corpus of the trust cannot be encumbered. The beneficiary is entitled to collect from the trust only that amount periodically that the trustee in his own discretion cares to give him.

Rights of the Creditors of the Insured in the Cash Values. In most states, the wording of the laws granting exemption from creditors' claims is broad enough to exempt cash values as well as proceeds. Where the statutes are not clear on the subject, court opinion has been divided. Usually, the use of the term "proceeds" in the statute without the addition of "avails" or "cash values" is held to restrict the protection to death proceeds only. Some courts, however, have held that whatever protection is afforded against the claims of the creditors of the insured in the proceeds extends also to the cash values. Actually, much depends upon the language of the statute involved.

Rights of the Creditors of the Beneficiary in the Cash Values. Most state statutes do not provide for protection against the claims of the creditors of the beneficiary. As for cash values, not much of a problem is created since the beneficiary does not have an absolute vested right in these values unless named irrevocably. Even then, many courts hold that the beneficiary cannot cash in the policy without the consent of the insured. Under this line of decisions, the beneficiary's creditors would have no rights without the consent of the insured because it is impossible for the creditors to exercise rights in the debtor's property that the debtor himself cannot exercise.

Rights of the Creditor When No State Statutes Apply. Where the policy is not protected by state statutes, the rights of creditors in the proceeds or

⁴³ Reference to the term "trust" in the exemption statutes and court decisions is a careless use of nomenclature because no trust actually is involved. The funds used to pay the principal and interest under life insurance settlement options are mingled with the general assets of the insurer and the relationship between the insurance company and the beneficiary is one of debtor-creditor only.

cash values of life insurance are governed either by common law or by federal statutes. Federal statutes governing are those applying to "GI" insurance and those relating to bankruptcy.

Common Law. Under common law, creditors' rights in life insurance proceeds and cash values depend upon how the beneficiary is named in the policy. If the insured or his estate is designated as beneficiary, the proceeds of the policy are considered a part of the general assets of his estate, and as such can be reached to satisfy a judgment obtained by the creditor against the insured. The availability of cash values to meet claims of creditors is not too clear, but the general rule is that a policy containing a cash value can be attached before maturity. Whether or not the creditors can collect the cash value of the policy appears to depend upon the policy provisions. These provisions are of two broad types. If delivery of the policy to the company for cancellation is all that is required as a condition of payment, the courts usually will allow creditors to obtain the cash values by effecting the delivery. If the right to have the cash values paid is an option to be exercised by the insured, the insurer is under no obligation to pay these values until the insured elects the option. The attaching creditors cannot make the election for him.

If the beneficiary is a third party, the proceeds of the policy paid to the beneficiary upon the death of the insured are held to belong to the beneficiary and may not be reached by the insured's creditors. The proceeds, however, are subject to the claims of the beneficiary's creditors. The cash values of the policy also are held to be judgment-proof in relation to the insured's creditors on the principle that the beneficiary's right cannot be defeated by the insured's creditors. It appears to make no difference whether the vesting in the beneficiary is absolute, conditional, or qualified. The rule generally is followed in cases involving both irrevocable and revocable beneficiary designations, for if the insured has reserved the right to change the beneficiary, the courts ordinarily will not require him to do so to satisfy a creditor's judgment. As for the creditors of the beneficiary, the cash values of a policy may be reached only if the beneficiary has been named irrevocably and has an absolute and unconditional vested interest.

Federal Statutes. Under a federal statute designed to protect veterans' benefits, the values of government life insurance are protected from the claims of creditors. This protection extends to the values before and after maturity of the policy and apply to the creditors of both the insured and the beneficiary.

When an insured becomes bankrupt, the Federal Bankruptcy Act applies. Two provisions of this Act affect the handling of life insurance. Section 6 of the Act states:

This Act shall not affect the allowance to bankrupts of the exemptions which are prescribed by the state laws in force at the time of the filing of the petition in bankruptcy . . .⁴⁴

⁴⁴ Although this provision does not mention life insurance, it was established in *Holden v. Stratton*, 198 U.S. 202 (1905) that policies exempt under state law are excluded from the bankruptcy irrespective of Section 70a, explained below.

As a result, policies which come under state exemption statutes are not subject to bankruptcy proceedings. For all other policies, Section 70a governs. Under this section, the trustee takes over the property of the bankrupt. Since policies payable to a third party without the right to change the beneficiary cannot be transferred by the insured, the trustee will not have the right to take them over. The trustee, however, may take the *net* cash values of all policies under which the insured has reserved the right to change the beneficiary.⁴⁵

A surrender of life insurance policies to obtain the cash values, however, might cause the insured and his beneficiary undue hardship. The policy might be an unusually favorable one with preferred settlement options, or the insured might no longer be insurable. Recognizing a possible hardship, Section 70a adds:

When any bankrupt who is a natural person shall have any insurance policy which has a cash surrender value . . . he may, within 30 days after the cash surrender value has been ascertained and stated to the trustee, . . . pay or secure to the trustee the sum so ascertained and stated and continue such policy free from the claims of the creditors . . .

Under this provision, the insured can continue the policy in force by paying over its cash surrender value to the trustee. A possible source of funds for use in complying with this provision, of course, is a loan secured by the cash values of the policy.

Rights of the Government as Income Tax Creditor. In order to understand the rights of the government as an income tax creditor of the insured, a distinction must be made between cash values and death proceeds. The laws exempting cash values from claims of the insured's creditors do not ordinarily exempt them from the government's claim for tax liabilities.⁴⁶ Policies with an irrevocable beneficiary designation or which have been assigned to the beneficiary are exempt from such a claim because the property rights belong to the beneficiary, not the tax-liable insured. However, if the designation or assignment has been made with intent to defraud the government, the beneficiary may be held liable for the insured's tax up to the extent of the cash value. Death proceeds paid to a named beneficiary are not subject, however, to the government's claim for taxes, except that the government can hold the beneficiary liable as a transferee for the cash value of the policy at the time of the insured's death minus any loan outstanding against the policy.⁴⁷ If the estate of the insured is the beneficiary under the policy, then of course the policy proceeds, like all other estate assets, are subject to the federal government's tax claims.

⁴⁵ The trustees are entitled only to the *net* cash values. If the insured had already borrowed these values under the policy loan provision or if a failure to pay premiums has placed the policy under the extended-term, nonforfeiture option, there are no *net* values available for the trustee.

⁴⁶ Cf. *Cannon v. Nicholas*, U.S.C.A., 80F. (2nd) 934 and *U.S. v. Steele*, U.S.D.C.-N.Y., 9/7/39. Except that by Treasury ruling the cash surrender values of war risk insurance policies are not subject to distraint proceedings for the collection of delinquent federal income taxes. Cf. GCM, IRB-XV-7-7957.

⁴⁷ Cf. Chapter 1.

Two Exceptions. Two broad exceptions are made to the established rules in this section. Creditors of the insured may attach the proceeds or cash values of a life insurance contract regardless of how the policy is set up if (1) the premiums are paid from embezzled funds, or (2) premiums are paid while the insured is insolvent and in fraud of creditors. The burden of proof, of course, is on the creditor, and it is not easy to establish.

In the event that life insurance is purchased with embezzled funds and thereafter becomes a claim, the general rule is that the victim of the embezzlement is entitled to recover that part of the proceeds of the policy which has been purchased by these funds, i e., the percentage of the proceeds which equals the percentage that the embezzled funds bear to the total premiums paid. Contrary opinion requires simply a return of the embezzled funds with interest.

An insolvent debtor can pay premiums for a reasonable amount of life insurance to protect his family without prejudicing the insurance to the rights of his creditors. This is the law in the absence of fraudulent intent. If fraud is established, the creditors may recover from the proceeds of the policy up to the extent of the premiums paid plus interest.

The Illinois Statute. To this point the discussion of necessity has been general. For a quick reference to the laws of any given state, see the *Digest of Insurance Exemption Laws*, published by Research and Review in its *Advanced Underwriting Service*⁴⁸ or look directly into the state statutes involved.

For illustrative purposes, the following is a digest of the Illinois law relating to both life insurance exemptions and spendthrift trusts.

LIFE INSURANCE: The statute provides that all proceeds payable because of the death of the insured, and the aggregate cash value of any or all life and endowment policies and annuity contracts payable to a wife or husband of the insured, or to a child, parent or other person dependent upon the insured, whether or not the right to change the beneficiary is reserved, and whether or not the insured or his estate is a contingent beneficiary, shall be exempt from execution, attachment, garnishment or other process for the debts and liabilities of the insured, except as to premiums paid in fraud of creditors.

SPENDTHRIFT TRUSTS: The statute provides that any domestic life company may hold the proceeds of any policy issued by it with such exemptions from claims of creditors of beneficiaries other than the policyholder as shall have been agreed to in writing by such company and the policyholder. The same rule applies to a foreign or alien company when authorized by its charter or laws of its domicile.

3. POWER OF AGENCY.

Life and health insurance operate through a system of agents. Companies grant to selected individuals the power of agency. The power of agency is much broader than the power of attorney: the power of attorney is power to act *for*

⁴⁸ Address: 123 West North Street, Indianapolis, Indiana.

the company in legal matters, but the power of agency is the power to act *as* the company for one or more specific purposes. The agent's knowledge is presumed to be the company's knowledge, and the company's knowledge is presumed to be his knowledge.⁴⁹

Types of Agents. Two types of agents may be distinguished: general agents and special agents. A general agent is empowered to act as the company in all matters. A special agent is empowered to act in certain matters only.

Unfortunately, there is confusion in the insurance business between legal terms and common usage of the word "agent." It is common to use the term "general agent" to describe an agent who is empowered to appoint subagents in a given territory. Actually, he is not a "general" agent because he is authorized by his agency contract to act for the company only in certain matters: appointment of subagents in his territory, solicitation of new business, collection of premiums, and related matters. He cannot bind the company on other matters reserved for executive officers. Executive officers are the only true *general agents* of the company. What is commonly called a "general agent" in life and health insurance is actually a "special agent"; the man who is usually called an "agent" is actually a "subagent."⁵⁰

In a discussion of the legal aspects of agency from the point of view of life and health insurance, four matters need consideration: presumption of agency; authority of agents; limitation of the powers of agency, and the responsibility of principals for acts of agents.

Presumption of Agency. If a company has supplied an individual with forms and other materials which make it logical for anyone to presume that such individual is an agent of the company, it is likely that a court would hold that a presumption of agency exists. Under these conditions the company would be bound by the acts of this individual as though he had been given the express authority presumed in this case. For instance, if a former agent is allowed to retain materials which could lead the public to assume that he is still an agent, he would probably be held to have a presumptive power of agency.

On the other hand, there is no reason to assume that a man is an agent for a company merely because he represents himself as an agent. He must be so equipped or so presented by the company as to raise a reasonable presumption on the part of the public that he is so empowered.

Authority of Agents. The authority of the insurance agent is set forth in his agency contract. For the soliciting agent, that authority usually includes soliciting and taking applications for new business, arranging medical examinations, collecting the first year's premium and, in some instances, accepting re-

⁴⁹ This is a very broad generalization to which there are many exceptions. For a collection of interesting cases on agency in life and health insurance, see Barry Oakes, *Principal, Agent, and the Public*, Conference on Insurance, University of Chicago Law School, Conference Series Number 14, 1954.

⁵⁰ A "subagent" who has the authority to appoint other "subagents" often is called a "district agent."

newal premiums in exchange for renewal receipts properly signed by the company. Rights usually specifically excluded are to make, alter, or discharge any contract; to waive any forfeiture; to waive payment in cash; to extend the time of payment for any premium, or to accept payment of a past-due premium; to approve evidence of good health; or to accept any money due the company other than premiums, as described.

Implied Authority. In addition to the express authority granted by contract, the agent is held in common law to have certain implied authority. For example, any authority which the public may reasonably assume an agent to have is implied as long as the public has not been notified to the contrary. It arises from the realization that it is unreasonable to expect the public to scrutinize the actual agency contract before dealing with the agent.

The doctrine of implied power, however, does not mean that the public can assume that an agent has the power to do whatever he pleases. For the presumption to exist, there must be an action or lack of action on the part of the company (1) that gives the impression that its agent has the authority in question or (2) that fails to correct the impression that an agent does not actually have the express authority for the disputed act. For instance, it is well-established practice in the business for an agent to accept the first premium. If a company were to deny this power to an agent, it almost certainly would be held that the agent had the power under the doctrine of implied authority, assuming, of course, that the third party did not know of this restriction. On the other hand, it is not a common practice among companies to empower soliciting agents to commit the company to mortgage loans. Therefore, the action of an agent in making such a commitment for the company is not likely to be held within the scope of implied authority.

Apparent Authority. Again, while the agent's contract expressly states that he does not have authority to accept a past-due premium, the court probably would hold that the agent had that power if he had frequently accepted such premiums in the past without protest from the company. The policyholder from whom he had accepted past-due premiums would have the right to assume that such acceptance was within the scope of his agency powers. This is the doctrine of apparent authority.

Limitations of the Power of Agency. Limitations of the power of agency must be properly communicated to the public. Announcements of such limitations contained in application forms and in the policy meet this requirement.⁵¹ Policies contain a provision to the effect that only certain designated officers of the company have the power to make or modify any contract of insurance, or to extend the time for paying a premium, and that the company shall not be bound by any promise or representation "heretofore or hereafter given by any agent or person other than the above."⁵² This clause serves as proper com-

⁵¹ The requirement also can be met by an oral or written communication which is not a part of the policy or the application.

⁵² Oddly enough, this clause does not always give the company the protection it

munication to the public of the limitations on the power of both special agents and company officers. Company officers not named obviously do not have the powers.⁵³

Responsibility of Principals. Since an agent is a principal within the scope of his power of agency, granted and apparent, the company is responsible for his acts. In fact, in the eyes of the law the acts of the agent and the acts of the company are one and the same. Further, limitations on the agent's authority must be in conformity with the general rules of law. A company cannot disclaim responsibility for any actions of the agent which are reasonable and necessary in the pursuit of his duties as an agent. To a limited extent, the company is even responsible for the misstatements and misrepresentations of its agents, even if fraudulent in nature. In event of misrepresentations or fraudulent promises on the part of the agent, the applicant can demand and receive a refund of premiums paid. Usually, however, the company cannot be forced to live up to these misrepresentations or fraudulent promises.

As has been stated, the knowledge of the agent is assumed to be the knowledge of the company. Therefore, if the agent knows a material fact about the application, the applicant has a right to presume that he has given that information to the company. The fact that the agent may have failed to communicate the information to the company is no defense for the company. For instance, assume that in answer to a question on the application, the applicant gives information to the agent that the agent knows would cause the company to "rate up" or reject the application. Assume further that the agent fails to record the answer or the adverse part of it. Should the company discover the information after the policy is issued, it cannot invoke the doctrines of concealment or misrepresentation to void the policy, since legally, when that information was given to the agent, the company had it.

The responsibility of the company, when an agent erroneously interprets a policy provision to an applicant or policyholder, depends on the provision involved and the jurisdiction in which the dispute is heard. In some jurisdictions, if the clause is ambiguous in wording, it will be held that the agent's interpretation is valid. If, on the other hand, the wording is so clear that any

desires. For example, in *West v. National Casualty Company*, 112 N.E. 115, the court accepted the principle that the agent can waive the clause which restricts his power to alter or modify the policy. The reasoning in the case was that an agent operating within his actual or apparent authority may waive any clause beneficial to the insurer since he is the insurer. Thus, the agent can waive the clause which prohibits him from waiving clauses, and, after that, waive whatever clause he wishes that is in the company's favor. However, when the restrictions are put in the application, the insured is on notice before the contract becomes effective, thus largely negating the situation which occurred in this particular case.

⁵³ In general, any limitation on the powers of general agents (that is, company officers) contained in the company's charter is effective. A charter is assumed to be public knowledge. However, restrictions in the bylaws would not be effective—unless properly communicated—because bylaws are not public knowledge. In general, the public has the right to assume, unless otherwise notified, that general agents (company officers) have all powers necessary to carry out the contracts of the company.

reasonable person could see by reading it that the agent was misinterpreting the clause, the company would not be held to the misinterpretation. In other jurisdictions the agent's opinion is given no weight at all.

While conducting the medical examination, the examining physician is the agent of the company. His concealment of or failure to report any facts found by him or revealed to him by the applicant is the responsibility of the company.

Brokers as Agents. In most jurisdictions there is a difference between the relationship among insured, broker, and company and that existing among insured, agent, and company. Generally speaking, the broker is the agent of the *insured*, not of the *company*. Technically, the insured, or prospective insured, empowers the broker to act for him as his agent in obtaining insurance. Consequently, the actions of the broker are not held to be binding upon the company. In insurance law, however, there are exceptions. Some states have statutes which make anyone who solicits insurance for persons other than himself, the agent of the *insurer* on all policies arising out of the solicitation. Some states make the broker the agent of the company only for delivering the policy and collecting the premium. Therefore, it becomes necessary to look to state law to determine whether or not a statutory agency has been created out of the operations of the broker. If so, the statutes must be examined further to determine whether the agency is created for *all* or just *some* of the broker's operations.

4. SUMMARY.

The life and health insurance policy is a legal contract and, as such, is subject to the general law of contracts, with a number of variations. To be a valid contract, it must possess the requisites of a contract: offer, acceptance, consideration, and legal purpose. It has a number of distinguishing characteristics which affect the law of contract as applied to it: It is a contract of utmost good faith, an executory contract, a unilateral contract, a conditional contract, a valued contract, a contract of adhesion, and an aleatory contract.

An insurance policy is held to be against public policy unless there is an insurable interest, except where a person takes insurance on his own life. An insurable interest may be defined briefly as a pecuniary interest in the continued life of the person insured. Mere family relationship alone is not always sufficient to establish insurable interest. On the other hand, support of the applicant by the insured does constitute insurable interest, even if no family relationship is involved and even if that support is not a legal obligation. Insurable interest need exist only at the time the policy originates.

Statements on an application are, in the absence of fraud, representations and not warranties; i.e., they are approximations to the best of the knowledge and belief of the applicant and are not warranted to be exact in detail. In general, an unintentional misrepresentation is cause for voiding the policy if

it is material; i.e., if the company would not have issued the policy at the rate charged had it known the correct details.

Concealment may also be cause for voiding the policy. However, the applicant is not required to volunteer information not asked for on the application or which may be presumed to be knowledge by the company. Concealment exists only if the applicant is asked a question and does not answer or answers only partially. Concealment must be both intentional and of a material fact to void the policy.

The life insurance policy may be said to be "sheltered property" where creditors are concerned. While the rights of creditors in policy proceeds vary from state to state, they are nearly always severely restricted. Further, the policyholder may usually specify in settlement agreements that the beneficiary shall have no power to encumber, alienate, or assign the unpaid portion of any proceeds being settled on an installment basis.

In many states the wording of the law exempting proceeds is broad enough to extend to cash values. Where the law is not clear, court decisions are diverse.

In the absence of bankruptcy, the insured seems to have rather effective protection under common law. State exemption statutes, therefore, are particularly useful in the event of the bankruptcy of the insured.

Life insurance companies are corporations. The corporation is a legal "person" but not an actual person. Therefore, it must operate through actual persons who are designated as "agents." An agent is a natural person who is empowered to act as the corporation. In most corporations, the general agents of the corporation are its executive officers, or those executive officers designated by the charter.

In addition to general agents, the life insurance corporation transacts much of its business with policyholders and applicants through a system of special and subagents. Its special agents are empowered to act for it in certain matters relating to the solicitation of new insurance and servicing of old. Such special agents may delegate certain of their powers to subagents.

Unfortunately for the clarity of the discussion of agency, it is the custom to call special agents (who have the authority to designate subagents for soliciting and servicing policyholders) "general agents," and to call subagents "agents."⁵⁴

The authority of an agent is set forth in his agency contract. However, it is broadened by the doctrine of "implied authority." This doctrine holds that if it is reasonable for the public to assume that an agent has certain powers, he is legally held to have them. There must, of course, be a reason for the assumption.

An agent is not merely a *representative* of the company; he *is* the com-

⁵⁴ In fact, some companies call subagents "special agents," which confuses the matter even further.

pany, in so far as his agency powers are concerned. Therefore, his actions are binding upon the company. Since his knowledge also is presumed to be the knowledge of the company, information imparted to him is legally imparted to the company.

No brief statement such as contained in this chapter can be more than a general review, subject to infinite contrary court decisions and varying discursions. In the first place, the various jurisdictions which make up the United States and its districts and territories vary in their statutes relating to any part of the subject. To add to the confusion, various courts of the same jurisdiction will not always react in the same way. For nearly every statement made in this chapter, at least one contrary court decision could be found.

QUESTIONS FOR CLASS DISCUSSION

1. Two years before applying for the policy, the insured had consulted a physician and was told he had no heart condition. The insured failed to report these consultations on the application. The insured died seven months after the policy was issued. Is the company liable?
2. In October, 1960, the insured applied for the policy upon his life, and he was examined by the company's physician. The physician discovered that the insured had abnormal blood pressure, resulting from the presence of one or more specific diseases, not identified by that symptom alone. The application showed that the insured had undergone an appendectomy. The company refused to issue the regular policy, but agreed to issue the policy as a sub-standard risk, and a higher premium was charged. The application provided that no contract should be effective until delivered to the insured during good health, and the company later denied liability on the ground that the insured was not in good health at the time the policy was delivered. Is the company liable?
3. The insured and beneficiary were in a saloon when the company's agent complained about business being poor. In jest, the insured stated that he would be glad to take out a policy and name his companion as the beneficiary if the companion would pay the premium. His companion accepted the offer, and the insured signed the application for \$1,000. He stated that his health was good. He died four months later, and the company then learned that he had been examined in a local hospital a month after the policy was issued and was found to be suffering from heart disease. He died as a result of coronary occlusion a little over three months after the policy was issued. Can the beneficiary collect under the policy?
4. The insurance company reduced payment of disability benefits after the insured became 60 years of age, relying upon the provision that all indemnities payable under the policy would automatically be reduced 50 per cent after the insured became 60 years old. The insured became totally disabled about three months before the age limit, and the company commenced payment of benefits. After the 60th birthday, the company reduced the benefits one-half. The insured on advice of the agent construed the age limit provision to mean that the benefits

would be reduced in the event of disability occurring after the insured became 60 years of age. Therefore he sued for recovery of full benefits. How should the case be decided?

5. The policy was issued on May 14, 1959, and, at that time, the insured was up and around the house, cooking, cleaning, performing her household duties, and caring for her husband and two children. The company denied liability because she was not in good health at the time the policy was issued but was, in fact, suffering from cancer. She died October 15, 1959. The family physician testified that the insured consulted him about female trouble several weeks prior to April 8, 1958. On that date he did a biopsy and submitted it to a pathologist. After receiving the report from the pathologist that cancer was present, he did a total hysterectomy. After the operation the patient underwent radium treatment and deep therapy. However, an edema showed up two or three months prior to her death and she was under constant medical care thereafter. Her physician testified that she had cancer at all times and was never free of it. He stated further that he told her after the radium treatment that she was all right "because she was an individual who couldn't be told the facts." He didn't recall whether he had told her husband the truth. Is the company liable?
6. At the time of his death the insured was insolvent, and he owed income taxes in excess of the amount due on his insurance policy—\$12,597.70. His insurance policy was payable to his widow as beneficiary, and the United States brought an action to recover the unpaid income taxes from the widow to the extent of the policy proceeds. An Illinois statute exempts insurance proceeds payable to the widow from claims of creditors. Is the Government entitled to recovery?
7. A wife shot her husband in a Southern state. In spite of the fact that common law prohibits a criminal from benefiting financially from her crime, the widow collected a substantial part of her husband's insurance proceeds. How is this possible?
8. The premium on Mr. Green's life insurance policy was due on January 30, the day he died. Can the insurance company deduct the annual premium from the death claim? Discuss.
9. Distinguish between implied and apparent authority of a life insurance agent.
10. How does a life insurance contract differ from other contracts? In what ways is it similar?

CHAPTER 9

General Policy Provisions

It is perhaps a tribute to the insurance business and the regulation of it that an insurance contract can be called the nation's least read best seller. Nearly everybody believes in life insurance, and the majority of people buy it; yet few policyholders ever read a life insurance contract all the way through with any attempt to understand its various provisions. This is sometimes unfortunate, for policyholders frequently have the most garbled impression of what any particular policy promises.

A life insurance policy is a legal contract, its validity as such having been established in the United States since 1815.¹ As a contract, it contains provisions setting forth the rights and duties of the policyholder and the company. Although it is necessary to look beyond the policy into statutes or court decisions for the interpretation and full effect of policy provisions, these provisions nevertheless are the basis of the agreement between the company and the policyholder (and the beneficiary, estate, heirs, or assigns of the policyholder, as a matter of fact).

1. STATUTORY LAW RELATING TO POLICY CONTRACT.

The provisions of the policy contract are closely regulated by statutory law. Most state insurance codes provide for certain (1) mandatory provisions, (2) prohibited provisions, and (3) permissible provisions.

Mandatory Provisions. While in life insurance there are no "standard policies" ² such as may be found in fire insurance, nearly all states require the inclusion of several fundamental provisions in every policy issued in their jurisdiction. The law sets forth the substance of these provisions, which form the minimum requirement. Other wording of the mandatory provisions, if more favorable to the policyholder, may be substituted. If a mandatory

¹ *Lord v. Ball*, 12 Mass. 115 (1815).

² Standard policies were attempted in New York following the Armstrong investigation in 1906. Four other states passed similar legislation in 1907. Standard policies were abandoned in 1909. (For a discussion of reasons, cf. Krueger and Waggoner, eds., *The Life Insurance Policy Contract*, Boston, Little, Brown & Co., 1953, pp. 339 f.) In lieu of the standard policy, New York adopted a set of provisions required in substance. These provisions are the basis of the mandatory or "standard" provisions now required in almost all states. They should not be confused with the 1912 Standard Provisions for health policies or the Uniform Provisions for health policies discussed in Chapter 11.

provision is left out of a policy, the courts will interpret the contract as though it contained the minimum provision.

With some variation among the states, mandatory provisions usually cover (1) a grace period; (2) incontestability; (3) entire contract; (4) misstatement of age, (5) policy dividend distribution in the case of participating contracts; (6) options available in event of default in payment of premium; (7) loans and table of loan values, (8) table of installment payments under available settlement options; (9) reinstatement; (10) dividend options; (11) valuation of nonforfeiture provisions; (12) deferment of loan and cash value payments.

Each of these provisions will be discussed either later in this chapter or in Chapter 10.

The fact that there is no standard policy in life insurance, plus the fact that mandatory provisions do not specify the exact wording but only the minimum requirements, leaves room for companies to draw up policy contracts more liberal than the law requires. Competition, therefore, produces some variations among policy forms and provisions.

Prohibited Provisions. In addition to requiring minimum provisions, the laws also prohibit the inclusion of certain other clauses. Examples of prohibited provisions are (1) forfeiture because of failure to repay a loan while indebtedness under a policy is less than its cash value; (2) limiting the time in which an action in law or equity may be commenced to fewer than two years after the cause of the action; (3) backdating a policy for more than a specific period (commonly, six months) before the original application was made; (4) requiring warranties in the application; (5) providing that the rights and obligations of the policy shall be governed by the laws of a state other than that in which the policy was issued; (6) excluding or restricting liability for death caused in a specified manner except certain permissible exclusions; (7) a provision for any mode of settlement at maturity of less value than the amount insured by the policy;³ (8) assessable clause (New York) If a prohibited provision is inserted in a contract, the courts will interpret the policy as though the provision did not appear.

Permissible Provisions. The law requires the inclusion of some provisions, it prohibits the inclusion of others, and it allows but does not require another set of provisions. The permissible provisions apply to the exclusion of coverage in event of (1) death from military service in wartime; (2) death within five years as a result of war while traveling outside the United States, its possessions, or Canada; (3) suicide within two years from the policy's date of issue; (4) death resulting from certain types of aviation; (5) death resulting from certain hazardous occupations, if it occurs within two years from the date of issue.

³ The latter restriction would prohibit a company from calling a policy paying \$100 a month for ten years a \$12,000 policy. It must express the face in terms of its commuted value.

The provisions of a life insurance policy may be classified under the headings of *insuring agreement*, *general provisions*, *nonforfeiture options*, *settlement options*, and—in the case of participating policies—*dividend options*. This chapter will consider the insuring and general provisions. Nonforfeiture, settlement, and dividend provisions will be discussed in Chapter 10.

2. INSURING CLAUSE AND CONSIDERATION.

The insuring agreement and the consideration clause are usually (but not always)⁴ found on the face of the contract as the opening statement.

Insuring Agreement. In the insuring clause, the company agrees to pay the face amount of the policy immediately upon receipt in writing of due proof of the death of the insured, provided premiums have been duly paid, the policy is in force, and is then surrendered or properly released. The agreement is subject to all the conditions, benefits, and privileges described in the policy pages, which are made a part of the contract.

The insuring clause varies slightly according to the type of policy. The clause as detailed above applies to whole life contracts.

Consideration Clause. In some clauses the consideration is the advance payment of the first premium or an installment thereon. In others, the consideration includes both the premium payment and the application.⁵ Payment of subsequent premiums is a condition precedent to the promise of the company to keep the policy in force.

There is confusion in law as to what constitutes payment of the premium. Does it have to be in cash? Can it be by check? Will a promissory note be sufficient?

A check is customarily considered cash and therefore fulfills the cash payment condition. What if the check is no good? If the company agrees to accept the check as absolute payment rather than conditional payment, then acceptance of a check for the full first premium binds the contract even if the check is no good. In this case the insurer has the right only to court action for recovery of the amount of the check. Most checks, however, are accepted as conditional payment. In these cases the courts rule that the debt is unpaid if the check is not honored. Thus, the first full premium is not considered paid, and the contract is not in force. Companies usually include a condition in the contract to the effect that “no check or bank draft accepted in exchange for

⁴ A survey of the policies of twelve companies in the portfolio of one of the authors reveals that eight carry the consideration clause on the face and four carry it elsewhere. This is no implication that the ratio would hold if the policies of all companies were surveyed, but only that there is variation in the location of the clause among policies of different companies.

⁵ The same survey mentioned in footnote No. 4 revealed that five companies make the premium the only consideration, while seven make the consideration both the premium and the application. It is felt in these latter companies that including the application as part of the consideration emphasizes the fact that the application is a part of the policy contract.

this receipt shall be considered as cash unless payment is received upon presentation to the proper bank.”

Many companies do not consider a promissory note the equivalent of cash. A note, therefore, is not adequate consideration for the issuance of a conditional receipt. If, however, the company has granted the agent authority to deal in promissory notes, the cash payment clause is waived, and the note becomes adequate consideration for the issuance of a conditional receipt. What happens if the note is not honored when it matures? The general rule is that unless the note, premium receipt, or policy (one or the other depending upon the jurisdiction) contains a stipulation that the policy will be repudiated if the note is not honored at maturity, the premium is considered paid and the action of the company is limited to its rights on the note. Thus, once a note is unconditionally accepted in payment of a premium *by an agent who has the authority to accept it*, the premium is considered paid, and the policy becomes independent of the note.⁶

Attestation Clause. The face of the policy concludes with an attestation clause on the order of, “In witness whereof, the Blank Insurance Company has caused this policy to be signed as of the — day of —, 19—,” followed by the printed facsimiles of the signatures of the secretary and the president of the company and actually signed or initialed by the policy registrar, examiner, or similar official authorized to do so. Occasionally, the attestation will be found at the close of the policy.

3. GENERAL PROVISIONS.

The general provisions of the policy usually consist of the mandatory provisions plus various permissible and miscellaneous provisions. Each of these will be discussed briefly.⁷

Ownership Clause. The person in whom the ownership privileges of the policy are vested is named. He may be the subject of the insurance (commonly called the insured) or he may be the beneficiary. He may even be someone other than the subject or the beneficiary. Ownership privileges are the right before the death of the insured to assign, transfer, or agree to any modification of the policy; without the consent of any beneficiary, to change the beneficiary at will; and to receive every benefit and exercise every option, right, and privilege provided in the policy or allowed by the company to the owner. Thus, the policy owner has the right to receive cash values, loans, dividends (if

⁶ Some agents who are not authorized to extend credit on behalf of their companies independently extend credit to their policyholders by paying the premium for them. If the policyholder fails to reimburse the agent for the premium when the debt falls due, the policy is unaffected since the financing transaction is independent of the policy contract.

⁷ It is beyond the scope of this book to give a definitive analysis of each provision or to go into the various case law ramifications. These details are interesting and in fact sometimes amusing but have educational value only for those specializing in the law. If interested and time is available, see Krueger and Waggoner, *op. cit.*

any), and other benefits accruing under the policy. The term "owner" means the named owner, his successor or transferee. Upon the death of the insured, ownership of the policy becomes vested in the beneficiary.

Entire Contract. The policy and the attached application are made the entire contract between the company and the insured or policy owner. No statement made by the insured or on his behalf shall void the policy or be used in defense to a claim under the policy unless it is contained in the written application. This clause is statutory in most states, and one of its purposes is to prevent the company from making its bylaws, charter, or any other instrument not in the contract a part of the policy. At one time, the practice of making the charter and bylaws of the company a part of the insurance contract was prevalent. This worked a hardship on the policyholder. In the first place, the policyholder rarely knew what was in the company bylaws and charter. In the second place, a change in these instruments would change his contract of insurance, probably without his knowledge.

Actually, the policy, application, and amendments are not the entire contract, despite the statement to that effect in every policy. Statutory law is also a part of every contract, as is judicial or case law. The policyholder and company cannot waive the benefits of the law even by mutual agreement. The matter is further complicated by the fact that although it is clear that the law is a part of every policy contract, under the existing system of state-by-state regulation and varying common law interpretations, it is not always clear which is the governing law. Consider the following situation: The policy has been issued in one state by a company domiciled in another. The policyholder has moved to a third state. He has several co-beneficiaries who reside in still different states. Laws often vary from state to state, and court decisions may vary by jurisdictions. Which law applies has been the subject of conflicting court decisions in the past.

The majority rule is that the validity and interpretation of the policy depend on the law of the state in which the last act creating the policy took place. Thus, if the first premium is collected when the policy is delivered, the state law governing will be that of the domicile of the policyholder. However, when the premium is paid in advance with the application, and a conditional receipt has been issued, the last act creating the policy is the acceptance by the company. Under these conditions, the law of the state of domicile of the company applies. This is known as the "contact" or "place-of-making" rule.

While the trend is toward the "contact" rule, other rules have been applied because of the varying court philosophies. Some courts, for example, have held that the laws of the state of domicile of the insured always govern; whereas other courts have held that the laws of the state of domicile of the company always control.

When there is a conflict of law, the rule used in resolving the conflict is that of the state in which the case is being tried. When the trial court deter-

mines which law governs, it must apply its own interpretation of that law even though that law happens to be one of another state. The Supreme Court of the United States has held ⁸ that federal courts also must follow the conflict of law rules prevailing in the state in which the case is heard. Finally, even though the policy contains a clause specifying the state law that is to govern the validity and interpretation of the contract, it appears that only the insured or his beneficiary is allowed the benefits of this clause. If its enforcement would favor the insurer, the clause is disallowed.⁹

Still other factors make it necessary to look beyond the policy despite the "entire contract" clause: Often, as mentioned, the conditional receipt, issued with the policy when settlement is made, contains provisions that are actually a part of the agreement between the policyholder and company. The law of most states does not require that an application for reinstatement of the policy after a lapse be attached to the policy; yet such an application is usually held to be a part of the contract inasmuch as the company can contest settlement if there has been misrepresentation in connection with reinstatement. Riders are a part of the contract if attached to it and made a part of it by reference, but courts have held that such riders need not be signed by both the policyholder and the company to be effective. A few courts have held that even advertising material is a part of the policy contract, although the decision is not general. Some courts have held that the "entire contract" requirement does not preclude the use of subsequent agreements, since the requirement and provision refer only to the contract at the time it is first issued.

In other words, while the "entire contract" clause does prevent the company from making its charter or bylaws a part of the contract, and prevents the company from using statements made by the insured or on his behalf as a defense against a claim unless they are written in the application, it does not in every case prevent the necessity for looking outside the policy for the whole contract.¹⁰

Premium Payment. The policy acknowledges receipt of the first premium and states the date on which subsequent premiums will be due. In ordinary policies, the basic period of premium payment is usually annual; however, the policyholder may, upon agreement with the company, pay premiums semi-annually, quarterly, or sometimes monthly. Premiums are payable at the home office, agency office, or to an agent. Formerly it was the practice to issue a formal receipt signed by the company registrar or similar official and countersigned by a cashier. The statutes generally require that policies contain a provision for delivery of a receipt signed by a company officer and countersigned by the agent when premiums are paid to agents, but in the interest of

⁸ *Griffith v. McCoach*, 313 U.S. 549 (1941) and *Klaxon v. Sientor Electric*, 313 U.S. 487 (1941).

⁹ If this discussion sounds inconclusive and confusing, the simple fact is that it is inconclusive and confusing. Blame the courts, not the authors!

¹⁰ For an interesting discussion of this point, see *Trends in Life Insurance*, Daniel J. Reidy in the Insurance Lecture Series, University of Connecticut, Spring, 1953.

economy, most companies no longer issue receipts. Where the premium is paid by check, the check is sufficient receipt. Failure of an agent to give a receipt does not violate the provisions of the contract inasmuch as such receipts have been held for the protection of the company. The company can, of course, "waive its rights."

Commonly, but not always, calculation of the net premium is based on the assumption that it will be paid in advance. If this assumption is used, premiums paid more frequently than annually are merely installments of an annual premium. In event of death before the full annual premium has been paid, the unpaid installments can be properly deducted from the proceeds. However, the practice of deducting unpaid premium installments has been subject to public misunderstanding. Therefore, it has become the predominant practice to waive unpaid fractional premiums due after the date of death. Moreover, some companies make a provision for refund of a proportionate amount of any premium paid beyond the date of death, whether the premium is paid annually or fractionally. The effect of these practices is to increase the cost of insurance. The added expense of premium refunds can be handled by loading the premium for it.

Some companies incorporate a premium deposit provision in the contract under which money may be deposited in advance, at interest, and used to pay premiums as they fall due. According to company practice or contract provision, the fund may or may not be withdrawable, a minimum rate of interest may or may not be guaranteed, and the deposit fund upon death of the insured may or may not become a part of the policy proceeds to be distributed under one of the settlement options to be discussed in the next chapter.

The Grace Period. Most states require companies to include in their policies a "period of grace" after the premium-due date, during which period the policy remains in full force even though the premium has not been paid. The period is usually stated as "one month," "one month but not fewer than thirty-one days," or merely "thirty-one days." The law usually permits a provision for an interest charge from the due date to the date of payment on any premium paid during the grace period, but few, if any, companies require the charge. If death occurs during the grace period and before the premium has been paid, the amount of the premium due is deducted from the proceeds.

A relatively few states require the sending of premium notices,¹¹ usually not less than fifteen days nor more than forty-five days before premiums are due. The typical law in these few states prohibits the company from lapsing a policy within one year after default if it fails to comply with the notice provision. Therefore, in such states, failure to give a premium notice has the effect of extending the grace period to one year.

Reinstatement. If the premium is not paid within the grace period, the

¹¹ A second premium notice is rarely required. Companies formerly made a practice of sending a second notice. In the interest of economy, they have generally discontinued this plan.

policy lapses if it has no surrender value; otherwise, it is placed on one of the nonforfeiture opinions.¹² The policy, however, usually provides for reinstatement under certain conditions if applied for in a stated period after non-payment. Although reinstatement clauses are required by only half the states, they are nearly universally used. In those states requiring a reinstatement provision, the minimum period allowed is three years; however, the policy may offer a more liberal provision, and periods up to five or more years are found.¹³ Reinstatement clauses were voluntarily inserted into policies by a number of insurance companies long before they were required to do so. These clauses were first used before the advent of nonforfeiture provisions. They were designed to correct partially the inequity of making defaulting policyholders forfeit their interest in the policy completely and forever.

Reinstatement means that the policy is revived and the relationship between the policyholder and the company becomes the same as it was before the default in the payment of the premium. It is not a new policy but a revival of the old one. Reinstatement usually requires evidence of insurability satisfactory to the company and payment of all premiums in arrears with interest thereon at a specified rate. Naturally, the policy must not already have been surrendered to the company for cash.

Evidence of insurability, in case of reinstatement, is required to prevent selection against the company.¹⁴ If the premium default has been recent, the company usually requires only a statement from the policyholder certifying he is in good health. If the default is not recent, a medical examination may be required. Insurability means not only good health but also good habits, good morals, an acceptable occupation, and general conformance with the underwriting standard of the company. If the policyholder no longer meets these standards, his policy will not be reinstated.

Every life insurance policy contains a clause making it incontestable after a given period. What happens to the contestability of a reinstated policy? The majority rule seems to be that a reinstated policy again becomes contestable for the period provided but only as to the statements made by the applicant in applying for the reinstatement.¹⁵ Nearly every policy contains a suicide

¹² Except that if the policy contains a provision for, and the policyholder has elected to take advantage of, an automatic premium loan, the loan value up to the amount of the premium due will be used to pay the premium. If there is no automatic loan provision in effect, then any cash value may be used to keep the policy in force under one of the nonforfeiture benefits discussed in the next chapter.

¹³ A survey of policies reveals some containing provisions which place no time limit at all on reinstatement.

¹⁴ Selection against the company means, in this instance, that there could be a tendency for people who find their health impaired after lapsation to reinstate, whereas fewer of those who have no health impairment will take action to reinstate.

¹⁵ Among contrary opinions (all a small minority) are three theories. (1) A few courts have held that fraud in the application for reinstatement vitiates that application and therefore leaves the policy as it was—lapsed. It follows, therefore, according to this view, that reinstatement is not a contract but instead waiver of a lapse. (2) Other courts have held that reinstatement does not reopen the incontestability clause in the original

clause which limits the liability of the company to a return of premiums paid if the policyholder commits suicide within one or two years. Majority opinion holds that reinstatement does not reopen the suicide clause because the policy is not a new contract but a resumption of the old one.

For two basic reasons it is better for defaulting policyholders to reinstate old policies than take new ones. First, many old policies have more liberal settlement options, or they may have other desired provisions which no longer are available. Second, the policyholder eliminates the acquisition cost, which he would have to pay again were he to take a new policy. Reinstating old policies rather than purchasing new ones is usually the more economical way of re-establishing a given amount of insurance unless unusual circumstances are involved.

Incontestability. The incontestability clause in a life insurance policy makes it impossible for the company after a period of time (usually two years) to contest any statements made in the application or any concealment of material facts in order to avoid payment of the proceeds. The clause is usually a simple statement announcing that, except for nonpayment of premium, the policy is incontestable after a specified period of time. The clause means that, after the contestable period, the company cannot seek to set aside the policy on the grounds that it was obtained by misrepresentation or concealment.

The incontestability clause as found in life insurance contracts is an anomaly among contract provisions. The law of contracts holds that a contract involving fraud is voidable at the option of the aggrieved party. The innocent party may rescind the contract any time within the statute of limitations. The time limit allowed by the statute begins when the fraud is discovered and not when the contract is made. Further, the law usually holds that an agreement to disregard fraud is a violation of public policy and hence void.¹⁶ In view of these basic legal principles, it was not the intention of the incontestability clause to protect the beneficiary from fraud on the part of the insured, but to protect him only against innocent material misrepresentations.¹⁷ The courts, however, have interpreted the clause more broadly than expected and have allowed it to become an agreement to disregard fraud in the life insurance contract after a specified period. The clause has been in use since the 1860's, is required by many states, and has been held to apply in the most flagrant cases of fraud. Although there is social and economic justification for

policy but does subject the reinstated policy to contestability based on the reinstatement agreement which is of itself a new contract governed by all the common law principles relating to fraud. (3) Still other courts have held that the original contestable period applies. If it has expired by the time the policy is reinstated, the reinstated policy can not be contested.

¹⁶ When the clause makes the policy incontestable from the beginning, the courts will usually honor it in cases of simple misrepresentations and concealments but not in cases of fraud.

¹⁷ Some of the earlier incontestability clauses included the phrase, *except for fraud*.

incontestability in life insurance, there is no generally accepted legal explanation for the incontestability provision or for the decisions upholding it.¹⁸ It is a clause peculiar to life insurance contracts.¹⁹

The incontestability clause is designed to protect the policyholder and beneficiary against any attempt to set the policy aside, it does not, however, prevent a claim from being contested on the grounds that it is excluded from coverage under the terms of the contract. A defense against a claim is a suit to enforce contract provisions, not to set the contract aside. Similarly, it does not prohibit suits over construction of the policy or over its terms; nor does it bar a defense that the policy never went into force.

Since the incontestability clause is a provision of the contract, it has no force until there is a contract. If the contract legally never goes into effect, the clause is inoperative. For example, if an impersonator makes the application and takes the physical examination, or answers the health statements, the policy can be set aside even after the contestable period, since it is held that there was never mutual assent, as required for a valid contract, and that no contract ever existed.

As the clause itself is an anomaly among contract provisions, so is the inclusion of the wording, "except for nonpayment of premiums." The incontestability clause prevents setting aside the policy as of the beginning of the contract. Nonpayment of premiums does not set aside the policy from the beginning. The lapsing insured still has rights under the policy: reinstatement and nonforfeiture, for example. The wording seems to be a remnant of earlier days when some policies provided that in the event the premium was not paid, the policy would become void, thus voiding the policy from its beginning. The inclusion of the wording is now so well established that its omission might be looked upon by some courts as something different, and therefore subject to new rules of interpretation.

As has been pointed out, a defense against a claim on the grounds that it is improper or not covered is not, actually, a suit to avoid the policy but to

¹⁸ Horne and Mansfield in *The Life Insurance Contract* (2nd ed., New York, Life Office Management Association, 1948) refer to the incontestability clause as "something in the nature of a private contractual 'statute of limitations' to modify the statutory limitation." These authors quote the decision in *Clements v. Life Ins Co of Va*, 155 N.C. 57, 70 S.E. 1076 (1911) to the effect that the "courts will not aid those who sleep on their rights, but only those who are vigilant." A legal right must be asserted within a proper time or not at all, and with respect to the incontestability clause the proper time is the time fixed in the policy.

¹⁹ Lest this discussion create a one-sided impression, it should be pointed out that while it is true that the courts have interpreted factual situations which appear to be fraudulent in such a way that they are considered simply misrepresentations of material facts and within the protection of the incontestability clause, no court, to the knowledge of the authors, has construed a set of facts as fraudulent and then stated that once the contestable period has run, the company may not defend against a claim the payment of which would be against public policy. In fact, in the event of a gross fraud that would outrage public policy, the incontestability clause has been set aside. Thus, when a policy is taken out with the intent to murder the insured, the incontestability clause cannot be used to prevent the company from denying liability on the grounds of fraud.

enforce the conditions of the contract. Enough courts, however, have mistakenly held otherwise in the case of the disability and double indemnity provisions that the usual wording of some incontestability clauses has been altered to state an exception in the case of those provisions. Such a clause might read:

This policy shall be incontestable after two years from its date except for nonpayment of premiums and except for the restrictions and provisions applying to the double indemnity and disability benefits provided.

Other policies will seek to meet the situation by providing, in the riders adding disability and double indemnity, that the incontestability provisions of the policy do not apply to these riders.

The majority court opinion in early cases held that if the insured should die during the contestable period, the period continued to run. The reasoning seemed to be that since the clause is for the protection of the beneficiary as well as the insured, all terms of it also should apply to the beneficiary.

This interpretation led some companies to change the wording of the incontestability clause on new policies to read that the policy should be incontestable after having been in force for a given period. This attempt to prevent beneficiaries from obtaining the protection of the incontestability clause by withholding claim until the expiry of two years did not work according to expectations. Courts held that the policy was still "in force" after the death of the insured because it was running for the benefit of the beneficiary. Therefore, some companies have changed the clause to provide that the policy shall be incontestable after having been in force for the period specified during the lifetime of the insured. This wording has been held by virtually all courts to mean that upon the death of the insured during the contestable period, the policy can never become incontestable. This latter wording is the most common among incontestability clauses and has been adopted as part of the required policy provision laws in a number of states.

The practice of allowing parties to a life insurance contract to fix by stipulation the length of time after which fraud can be used as a defense is justified. The impracticability of assembling evidence and witnesses many years after issuance of the policy is clear. Defense against fraud is especially difficult if it must be made by a beneficiary after the death of the accused insured. The incontestability clause is particularly valuable to the beneficiary in preventing delayed settlement resulting from long, tedious, and costly court action. While it is true that the clause may allow some unscrupulous people to take unfair advantage of the insurer, the protection it gives the rank-and-file policyholder outweighs this limitation.

Misstatement of Age. Most state laws require that life insurance policies include a provision that if the age of the insured has been misstated, the amount of the insurance will be what the premium paid would have purchased at the correct age according to the company's published rate at the date the policy

was issued. For example, if a person aged 30 gives his age incorrectly as 25 when he purchases a \$10,000 non-par continuous-premium whole life policy for \$165.60, his coverage will be adjusted downward to about \$8,670 when his correct age becomes known. The published rates at the time the policy is issued for the company from which the above illustration is drawn are \$19.10 at age 30 and \$16.56 at age 25. At \$19.10 per \$1,000, \$165.60 will purchase \$8,670 of insurance. The clause also applies in event the age is incorrectly overstated. If the applicant mistakenly gives his age as 30 when it is 25, a \$10,000 continuous-premium whole life policy purchased for \$191 will be adjusted to about \$11,530 when the mistake in age is rectified.

Adjustment of the proceeds by reason of misstatement of age is not blocked by the incontestability clause. The adjustment is not a contest of the policy but an operation of a policy provision. A misstatement of age discovered during the contestable period, however, can give the insurer the right to rescind the contract if the underwriting rules of the company would not have permitted it to write the policy had the correct age been known. The effect of age on underwriting is discussed in Chapter 19.

Suicide. Nearly every policy contains a provision restricting the liability of the company in event of suicide. A typical clause reads, "If, within two years from date of issue hereof, the Insured shall die by his own act, whether sane or insane at the time, the company shall be liable for only an amount equal to the premiums paid hereon, without interest." In some policies the time limit is only one year. The clause developed as a result of (1) conflicting court decisions regarding the right of the beneficiary in the absence of such a clause to recover when the insured commits suicide, and (2) the attitude that while the insured should be spared the higher cost which would result if claims were paid on policies purchased in contemplation of self-destruction, such costs should not be controlled at the expense of the innocent beneficiary.²⁰

The one- or two-year exclusion of coverage offers the insurer some protection against the insured who fraudulently takes out a policy in contemplation of suicide. The innocent beneficiary is given some protection by allowing him to recover if suicide does not occur until the end of that period. The majority opinion of the courts today is that "suicide while sane or insane" can be properly excluded from coverage for a given period of years as in the standard

²⁰ Some courts have held, in the absence of suicide clauses, that inasmuch as the charge for insurance is based on mortality statistics which include deaths from all causes, coverage of suicide is not an undue cost burden on other policyholders. Cf., for one example, *Campbell v. Supreme Conclave*, 1.O.H., 66 N.J.L. 274, 49 Atl. 550, 54 L.R.A. 576 (Ct. Err. & App. 1901). In an earlier case, the U.S. Supreme Court held (*Ritter v. Mutual Life Insurance Co.*, 169 U.S. 139 [1898]) that the policy does not cover suicide if the policy remains silent on the subject because to do so would be against the public interest, and would not be carrying out the intentions of the contracting parties. This, however, is not the current view. The limited-duration exclusion of the modern suicide clause theoretically protects against the fraud involved in taking out a policy in contemplation of suicide while adhering to the theory that all deaths should be covered in the absence of fraud.

suicide clause if the contract so provides and if there is no state statutory prohibition against the suicide defense.²¹

Inasmuch as suicide is an exclusion of coverage by terms of the contract, most courts hold that it is not affected by the incontestability clause. Denial of a claim on the grounds of suicide under the suicide exclusion is not a contest of the policy but a suit to enforce a policy provision. Conflicts between the suicide and the incontestability clauses arise only when the suicide exclusion runs for a longer period than the incontestability clause.²² Since the type of incontestability clause now most widely used ceases to run upon the death of the insured, there is little possibility of conflict arising where the suicide period is less than or equal to the incontestable period.

Where suicide is suspected within the exclusion period, the burden of proof is on the defendant (the insurance company) to establish that the insured took his own life. Because of the instinct of self-preservation, where there is doubt the court always assumes that the death is unintentional rather than intentional. While the plaintiff has the benefit of the legalistic assumption that a sane man will not commit suicide, the presumption stands only until evidence is introduced to the contrary.

Loan Value. The company will make loans on the sole security of the policy at any time while it is in force except when the policy is under the extended-term, nonforfeiture option.²³ The loan may be for any amount which, with interest as specified in the contract, shall not exceed the cash value of the policy (and of any paid-up additions purchased with the policy dividends) at the end of the policy year in which the loan is made. Existing indebtedness to the company on the policy, including due and accrued interest and any unpaid premium for the year in which the loan is made, is deducted from the loan value. The granting of any loan, other than to pay premiums on the policy, usually may be deferred by the company for a period of not more than six months from the date of the loan application.²⁴

Loans are made at an interest rate stated in the policy, usually 5 per cent or 6 per cent, and the statutes require that the rate be level throughout the duration of the loan. Interest is payable at dates specified in the loan agree-

²¹ A Missouri statute (*Mo. Rev. Stat. Ann.*, paragraph 5851) makes the suicide defense available only where it can be shown that the insured took out the policy in contemplation of self-destruction. In New York State the suicide clause cannot contain the words, "sane or insane." In order for the clause to come into operation, it is necessary to establish that the insured was sane.

²² This might be the case in Virginia, for example, where a two-year suicide period but only a one-year incontestable period is allowed.

²³ The extended-term, nonforfeiture option is a provision under which the net cash value of the policy is used to purchase paid-up term insurance in an amount equal to the face amount of the policy extended for a period determined by applying the applicable premium rates to the values available. For detailed explanation, cf. Chapter 10.

²⁴ The deferment provision was added to policies generally after 1934 when the closing of banks led to fears of "runs" on cash values. However, some companies included deferment clauses in their policies prior to that time but often for periods less than six months.

ment, usually in advance on the anniversary date of the policy or at the time the premium falls due. Interest not paid when due is added to the amount of the loan and bears interest.²⁵ Loans may be repaid only while the policy is in force during the lifetime of the insured, but not if the policy has been placed on the extended-term, nonforfeiture provision. Failure to repay a loan or to pay interest will not terminate the insurance unless the total indebtedness equals or exceeds the loan value, and then not until thirty-one days after notice has been mailed to the last known address of the insured and any assignee of record.

A policy loan does not have the same legal effect as other forms of loans for it carries no obligation for repayment. Courts have held policy loans to be advances of funds which ultimately are payable to or at the direction of the policyholder either as cash values, matured endowments, or death benefits. The estate of the insured, therefore, is not liable for unpaid policy loans. The recourse of the insurer is to deduct any unpaid balance from the policy proceeds. For example, if an insured dies with a \$3,000 policy loan outstanding on a \$15,000 policy, the company will pay \$12,000 to the beneficiary. The beneficiary cannot recover the other \$3,000 from the insured's general estate because the loan is not a legal obligation of this estate.

Where there is an irrevocable beneficiary designation, the beneficiary must join the insured or owner in the request for the loan and in the loan agreement unless the policy states otherwise. In juvenile policies, the applicant, who is usually the parent, has the sole right to execute policy loan agreements until the child reaches maturity. If the law gives a juvenile the right to contract for life insurance in his own name at an age prior to legal majority,²⁶ the juvenile is then the owner of the policy and may exercise the loan rights contained in it. Where a juvenile or mental incompetent has a court-appointed guardian, the guardian may exercise the borrowing privilege under court approval. However, it has been held that if the insurer has no notice of mental incompetence, then a loan made upon application of the policy owner is made in good faith. The exclusive right of an assignee to borrow on the policy is clearly set forth in the standard assignment form developed by the American Bankers' Association and the Association of Life Insurance Legal Counsel, which has been accepted by the companies and which is discussed later in this chapter.

When the company makes a policy loan it usually requires that a proper loan agreement be sent to the company's home office together with the policy for endorsement. However, it has been held unnecessary for the company to have physical possession of the policy since it can prove the validity of the loan through the separate loan agreement, which in addition to the policy

²⁵ If the interest is paid by adding it to the loan rather than in cash it is not deductible for federal income tax purposes.

²⁶ As in New York, where a juvenile has the power to contract for insurance at age 15.

provision itself also sets forth the terms of the loan. Should the insured subsequently borrow from another lender on an unendorsed policy, representing to the lender that the policy is unencumbered, the insured is guilty of fraud. The lender probably would be held to have been negligent in making the loan since no assignment is binding on the company until the company is notified. If the lender had duly notified the company in advance of the loan, he would have learned of the existing policy loan. No lender who would do otherwise could be considered prudent.

The status of loan values when the insured is in bankruptcy is unclear. The United States Supreme Court has refused to review a federal appellate court decision²⁷ to the effect that the insurer must pay a trustee in bankruptcy the cash values of a bankrupt's policies even though it has already made a loan of the cash value to the bankrupt without knowing of his status.

The loan privilege in the life insurance contract is a valuable provision, because it enables a policyholder to draw upon cash values to meet a temporary financial reverse without forcing him to surrender his policy and lose his insurance.²⁸ If the policyholder has become uninsurable, the loan privilege is even more important to him. The danger of the loan privilege is its possible abuse. When a policyholder borrows on a policy, he must remember that he is borrowing on his family's future financial security, or, as it is sometimes put, he may be borrowing from his widow.

The question is often raised, "Why do you charge me interest to borrow my own money?"

This question arises from a misunderstanding of life insurance finance. When a policyholder borrows on the security of his policy, he is not borrowing his own money, but money which belongs to all policyholders as a group and money which must be invested at interest in order to support the premium structure of the company. The policyholder's equity in the company still continues to earn interest for him even though he has taken the money out by a loan.

This explanation inspires still another question: "Then why do you charge me 5 per cent or 6 per cent to borrow while you are paying me only 2½ per cent on my reserves?"²⁹

The net return on a policy loan is less than the 5 per cent or 6 per cent charged to the policyholder. It costs money to make and service policy loans, much more money than it costs to handle the typical investment in the company's portfolio.

Policy loans make up a sizable share of a company's investments. Even in good times, policyholder loans constitute 3 per cent or 4 per cent of all assets held by life insurance companies. In 1932, 18.34 per cent of assets were

²⁷ *Lake v. N.Y. Life et al.*

²⁸ Subject to the provisions of the deferment clause, previously mentioned and to be discussed more fully later.

²⁹ The term "my reserves" here is used in its loose and popular connotation rather than in the actuarial sense.

in policy loans. Like lapse ratios, and for the same reasons, policy loans fluctuate with economic conditions.

Automatic Premium Loan. Some policies include an automatic premium loan clause. In case of the policyholder's failure to pay a premium when due, it is paid out of the policy loan value. The typical clause states that it shall be operative if requested in the policy application or if a later written request is filed at the home office. The amount of loan value applied on the premium due is charged against the policy subject to the same terms and conditions as cash loans in respect to interest, failure to repay, and voiding of the policy. Thus, through the use of the automatic premium loan provision, a policyholder can guarantee his policy against lapse if he fails to pay a specific premium as long as the policy has sufficient loan value to cover the payment.

In some companies, automatic premium loan provisions are not included in the policy but are written as an endorsement upon request of the policyholder. In other companies, automatic premium loans are not generally made available either in the policy or as an endorsement, except in Rhode Island and Montana where the provision is required by state law. In these states, the clause is automatic unless the policyholder specifically "elects out" by selecting extended-term insurance or reduced paid-up insurance as the automatic option in the event of premium default. Outside of Montana and Rhode Island, when an automatic premium loan clause is available, it is usually of the "elect-in" type; i.e., it applies only if the policyholder specifically requests in advance that it be made operative. Automatic premium loan provisions are the rule with Canadian companies. Where the provision is available, the policyholder should insist upon making it operative in his contract,³⁰ for it is possible to overlook the payment of a premium. However, the automatic premium loan provision must not be abused by frequent reliance upon it. It should be treated only as protection against an oversight in paying the premium, or perhaps temporary inability to meet the premium when it falls due.

Assignment. A number of circumstances exist under which a policy owner might wish to assign his interest in a life insurance contract. Life insurance policies frequently are used as collateral for debts and are often transferred between people with or without consideration. Contrary to the rule in fire insurance where the contract is personal in nature, the owner of a life insurance policy has the right to assign the contract without the consent of the insurer as long as the assignment does not defeat the vested rights of others, such as, for example, an irrevocable beneficiary. The right of assignment in life insurance is so well established that no permissive clause is necessary in the policy. An assignment provision does appear in the contract, but it is concerned only with explaining the position of the company relative to an assignment.

The typical assignment clause declares (1) that the company shall not

³⁰ Many agents make it a practice to have the clause inserted for all applicants without asking the applicant.

be bound by any assignment until written notice (usually in the form of the original or a duplicate of the assignment document) has been filed with the company, (2) that the assignment shall be subject to any indebtedness to the company (thus giving the company a prior right over any assignee), and (3) that the company accepts no responsibility for the validity or effect of the assignment.

This clause does not mean that an assignment of which the company has no notice is void. It means only that the company has no obligation to an unrecorded assignee if it pays the cash values or proceeds to someone else before the assignee presents a claim. In the case of a contested assignment after a policy has become a death claim, the company would seek to pay the proceeds into court, thus discharging its contractual obligation and allowing the distribution of the proceeds to be decided by legal process.

Several problems can arise in connection with an assignment.

Duplicate Assignments. A situation can develop where more than one assignment has been given, the second having been made before the company was notified of the first. The majority rule is that the assignee first in point of date of assignment has the prior assignment, but an exception is made to this rule if the assignee fails to take proper precautions to protect his rights by requiring delivery of the policy and a notation of the assignment thereon. This is the so-called "American Rule." The "English Rule" is that the first assignee to give notice to the debtor prevails. The "English Rule" is in force in a number of states, although these states represent a minority.³¹ Controversies over the priority of assignments, however, are not matters in which the insurer needs to be arbitrator. As mentioned above, the practice of the companies is to pay the proceeds into court in case of disputes, and then let the court decide which assignee has the prior claim. If, however, the company pays the proceeds of the policy to a bona fide assignee who turns out not to be the preferred assignee, that assignee is allowed to retain the proceeds as long as no fraud is involved. Thus the preferred assignee must notify the company of his claim before the proceeds are paid to someone else in order to preserve his preferred position.

Failure to Revoke the Beneficiary. The beneficiary might not be revoked before the assignment is made.³² Where the beneficiary is revocable, in the absence of revocation the courts generally have held that the assignee has the prior claim on the grounds that a revocable beneficiary has no present interest

³¹ See Krueger and Waggoner, *op. cit.*, for the specific states in which each rule is applied.

³² If the policy contains the following clause (as some do), then no problem is created by failure to change the beneficiary: "Whenever an assignment is executed by an owner of a policy who has the reserved right to change the beneficiary, the effect of such assignment shall be to destroy the rights of any named beneficiary in favor of the assignee." Cf. "Assignments of Life Insurance Policies" by Robert Dechert in the *The Beneficiary in Life Insurance*, Philadelphia, University of Pennsylvania Press, 1948, p. 28.

but only a future expectation.³³ Therefore, if the assignee has established his interest at any time before the proceeds have been paid to the beneficiary, the assignee is entitled to recover. Also, when an absolute assignment (a form in which the ownership of the policy is to be fully and permanently transferred, as in a gift or a sale) rather than a collateral assignment (a form used when the policy is pledged as security for a loan) is intended, the assignment itself has been held to be notice of intention to change the beneficiary and has been interpreted by courts as a change. This interpretation cannot be applied in collateral assignments because the beneficiary is entitled to collect any proceeds in excess of the assignee's claim. Since in the past there has been a body of decisions upholding the revocable beneficiary's rights over those of the assignee where the beneficiary did not consent to or acknowledge the assignment, it would be a wise precaution for the assignee to obtain evidence of the consent of the named beneficiary at the time of the assignment or, even better, for the assignee to request that the beneficiary be changed to the insured's estate before the assignment is made. While this protection is not necessary under a majority opinion, courts do have a way of springing unhappy surprises. Such precaution also serves as protection against possible litigation brought on by beneficiaries,³⁴ but it creates a new danger in the case of collateral assignments: the insured may fail to reinstate the original beneficiary and settlement options when the assignment is terminated. This danger, however, can be avoided by using a clause which states in essence that the beneficiary in force immediately preceding the assignment is changed but is reinstated to the same effect subsequent to that assignment.

The problem takes on a different character when the beneficiary designation is irrevocable. Here the beneficiary must join in the assignment before it can be effective. An assignee of a policy containing an irrevocable beneficiary can exercise no rights in the policy unless the beneficiary consents.

In using a life insurance policy as collateral for a loan, conditional assignment is to be preferred to a change of beneficiary. If the beneficiary is changed to the lender, he then has the right to collect the full amount of the death benefits; if assignment is made, his right can be restricted to his interest "as it may appear." For example, assume a lender wishes to protect a \$5,000 loan should the insured die prior to repayment. It would seem at first glance that the simplest arrangement, in view of the confusion which exists over the rights of the beneficiary in assignments, would be to change the beneficiary on the policy to the creditor. But if the loan should be partially repaid before the death of the insured, then the contingent beneficiary will have to depend on the creditor for a refund of the difference between the proceeds and the

³³ The minority view, held in Colorado, Massachusetts, and New Jersey, is that the owner cannot assign the policy without the consent of the beneficiary unless he revokes the beneficiary designation.

³⁴ This procedure is required by companies in assignments involving policy loans if the policy does not take care of the problem through the contract provision itself.

amount still owed. This might involve the expense and delay of litigation. Proof that the change in beneficiary was to secure the debt might not be easily obtained where family relationships are involved. On the other hand, an assignment of the policy proceeds to the creditor as his interest may appear would automatically pay the beneficiary the difference between the \$5,000 proceeds and the amount of the debt still outstanding at the time of the death of the insured. Even here, however, where family relationships are involved, there might be litigation over the interest of the assignee at the time of the insured's death.

Failure to Follow Assignment Procedure. Most courts, again, will hold that the failure can defeat the assignee's claim. The company can, however, if it wishes, waive the notice requirement and pay the proceeds to the assignee; or it can ignore the assignment and pay the proceeds to the named beneficiary.

Assignment by Incompetent Owner. The general rule is that unless the company has notice of that incompetence, it has no liability for merely having accepted the assignment. The company takes care of these situations by including a statement in the assignment clause to the effect that the insurer accepts no responsibility for the validity of any assignment.³⁵

The Assignee Has no Insurable Interest. The general rule is that a life insurance policy may be assigned to a person who has no insurable interest. If the assignment arises from a debtor-creditor relationship, however, the creditor may collect under the policy only to the extent of his insurable interest. On the other hand, it has been held³⁶ that an absolute assignment made in exchange for a valuable consideration (a bona fide sale) can be effected to someone who has no insurable interest. This is the majority rule and is held in all except five states.³⁷

The ABA Assignment Form. The absolute assignment, designed to transfer ownership, gives the assignee all rights under the policy, both before and at its maturity, subject, of course, to any limitations in the policy.³⁸ The collateral assignment, designed to serve as security for a debt, restricts the rights of the assignee to the amount of the debt, interest thereon, and premiums paid on the policy. Creditors prefer the absolute assignment because the collateral assignment restricts their actions with respect to the policy. A compromise has resulted in the development of the American Bankers' Association's standard assignment form, which gives the assignee the rights he needs for complete freedom and security while at the same time granting the assignor the protection he needs in arranging his insurance. This assignment

³⁵ If the company were to accept any responsibility for the validity of assignments, such acceptance might be held to lend weight to the assignment, whereas the company should have no standing as a judge of such validities.

³⁶ The leading case is *A. H. Grigsby, Petitioner, v. R. L. Russell and Lillie Burchard, Administrators of John Burchard, Deceased*, 222 U.S. 149 (1911).

³⁷ Alabama, Kansas, Kentucky, Missouri, and Texas.

³⁸ For example, some policies prohibit assignees from electing settlement options and may also exclude the transfer of beneficial interest.

form was prepared by the American Bankers' Association and the Association of Life Insurance Counsel. It gives the assignee bank "all claims, options, privileges, rights, titles, and interest" in the policy and all riders or supplemental contracts in connection with it, including:

- (1) The right to collect the net proceeds.
- (2) The right to surrender the policy for its cash value.
- (3) The right to borrow on the policy.
- (4) The right to receive dividends.
- (5) The right to exercise the nonforfeiture rights.

Under the ABA form the assignee agrees, however, that he will turn over to the beneficiary the difference between the proceeds collected and the unpaid balance of the debt, that he will not surrender or borrow on the policy unless there has been default in the loan or in the payment of premiums by the assignor—and then not until after giving the assignor twenty days' notice—and that he will not prevent the assignor from changing the beneficiary, from electing any optional form of settlement, or from collecting disability benefits as long as such collection does not reduce the amount of insurance. The ABA form also specifies that the assignee shall assume no obligation to pay premiums, principal, or interest on policy loans. If he does pay these items they are added to the debt and draw interest until paid at an annual rate not exceeding 10 per cent.

Assignment by the Beneficiary. Unless blocked by the contract or by state law, the beneficiary may assign whatever interest he has in a policy. The value of the beneficiary's interest before the maturity of the policy depends upon the beneficiary designation. If the beneficiary is named irrevocably, then the beneficiary has a valuable interest to transfer. How much this interest is worth depends upon whether the beneficiary has to survive the insured to collect or whether the beneficiary can pass on his interest to his estate if he dies before the insured.

The value of the beneficiary's interest at maturity of the policy depends upon how the proceeds of the policy are to be settled. If they are to be paid in a lump sum, then the beneficiary is free to assign the whole amount, but if they are to be paid under a settlement option, the assignment must not defeat the rights of any contingent beneficiary. It will be recalled that spendthrift trust clauses and the laws of certain states designed to protect insurance proceeds from the beneficiary's creditors also limit the right of assignment by the beneficiary.

The Deferral Clause. Especially since the cash-value "runs" of the depression of the 1930's, it has been customary to include in many policies a clause declaring that the company has the right to defer the payment of the cash value or the making of a cash loan for a period not exceeding six months from the date of the application for such payment or for such loan. When the loan application is for the purpose of paying renewal premiums on policies

in the company, the deferment does not apply. The deferment clause sometimes applies also to withdrawal of proceeds retained at interest or commutation of guaranteed payments under settlement options. Although the clause itself is often required by statute, and therefore must be in the policy, the companies may use their own discretion in invoking it. The deferment clause is in line with a similar provision introduced into bank accounts as a result of experiences during the early 1930's when bank depositors demanded funds, not because these funds were needed, but simply because the depositors were afraid of the safety of these funds.

The Beneficiary Clause. In life insurance policies the owner usually names a beneficiary, i.e., the person who is to receive the proceeds of the policy upon receipt of due proof of the death of the insured. In fact, he may name several successive beneficiaries in the order in which they are to take priority should the primary beneficiary not survive the insured or not live to collect the full amount of the proceeds guaranteed under a settlement option. These successive beneficiaries are known as "contingent" or "secondary," "tertiary," etc. The beneficiaries and their relationship to the insured appear on the face of the policy.

Sometimes rather than a third party, the insured's estate is named as beneficiary. As will be explained in Chapter 17, a third-party beneficiary usually is preferable to the estate. In endowment policies the owner-insured usually designates himself to receive the proceeds in the event of his survival, and a third party to receive the proceeds if death occurs during the endowment period. When the owner of the policy is not the subject of the insurance, as when an employer insures the life of a key employee, the owner-applicant usually names himself as the beneficiary.

Third-party beneficiaries may be named either revocably or irrevocably. If the insured has reserved the right to change the beneficiary, he may at any time make a change without the beneficiary's permission upon conforming with the procedure for change as set forth in the policy. This procedure, in general, requires written notice to the company, with the change becoming effective only if endorsed on the policy.³⁹ The rights of any beneficiary usually are made subject to the rights of an assignee under any assignment by the owner. The beneficiary clause usually states that the right to revoke and change the beneficiary designation is reserved to the owner unless otherwise specified.

If the beneficiary has been named without reserving the right to change, the designation is called "irrevocable" and the person so named, an "irrevocable beneficiary." An irrevocable beneficiary designation can be changed only with the beneficiary's written consent.

³⁹ The modern trend is not to require beneficiary changes to be endorsed on the policy, because of the expense involved in handling the endorsements. The beneficiary clause in these policies simply states that the beneficiary may be changed by filing at the home office a written beneficiary designation in a form satisfactory to the company.

An irrevocable beneficiary designation may be absolute or reversionary. Under an *absolute* designation, the beneficiary has an unconditional vested interest in the policy and may exercise all rights in it independently of the insured. In this type of beneficiary arrangement, the policy will be a part of the beneficiary's estate should he predecease the insured, to be disposed of according to the beneficiary's will. The absolute beneficiary designation is not common.

A *reversionary* irrevocable beneficiary designation specifies that in the event that the beneficiary predeceases the insured, all rights in the policy revert to the insured. In this type of beneficiary designation, the beneficiary's interest is conditional rather than absolute because his death prior to that of the insured will defeat this interest. Since the insured retains a reversionary interest in the policy, the exercise of any rights under the contract will require the joint action of both the insured and the beneficiary unless the policy states otherwise.⁴⁰

If the contract does not state the nature of the disposition should the irrevocable beneficiary die before the insured, the majority of courts hold that the rights of the beneficiary pass on to his heirs. A substantial number of courts, however, hold that where the beneficiary is a donee or gratuitous beneficiary (i.e., not a creditor or purchaser for value), his rights terminate with his death and revert to the insured. This latter interpretation seems more in line with the intentions of the insured.

The fairly recent developments with respect to ownership clauses have drastically reduced the use of the irrevocable beneficiary designation. Under the ownership clause, the insured transfers all incidents of ownership in the policy to the beneficiary (or to anyone else that may be named). The ownership clause also can specify that the ownership rights shall vest in the insured if he should outlive the beneficiary.

If the beneficiary is named revocably, he has no vested rights in the policy until the death of the insured.⁴¹ The rights of the revocable beneficiary also become fixed upon the maturity of an endowment, unless the contract provides otherwise.

Cases arise in which, after the death of the insured, the beneficiary wishes to name his own beneficiary to receive the balance of any proceeds still payable. If this "beneficiary's beneficiary" is named irrevocably, no problem exists. However, if he is named revocably, controversy arises over whether the designation is testamentary in character—i.e., in the nature of a will rather than of a beneficiary designation. Insufficient litigation has involved the question to state a "majority opinion," although a number of able writers

⁴⁰ Some policies are written in which the insured retains all the rights in the policy except the right to change the beneficiary.

⁴¹ Horne and Mansfield, *op. cit.*, point out several cases in which courts have held a revocable designation to have the same legal effect as an irrevocable one. For example, delivery of the policy to the insured's wife in consideration of marriage gave her a vested interest which the insured could not defeat by naming another beneficiary.

on the subject argue that it is not testamentary in nature, and New York has passed legislation to the effect that the rights of a beneficiary's beneficiary are not to be voided on the grounds of noncompliance with the laws of wills and intestacies.

If no beneficiary is named in the policy, or if no beneficiary survives the insured, the proceeds unless otherwise provided are paid to the insured's estate, and their distribution becomes a matter of his will, or, if he has no will, of the laws of descent.⁴²

The beneficiary clause is the one provision the policy owner writes himself. It is his instruction for the disposition of the property (the proceeds). In that sense, it corresponds to a will, *but only in that sense*. A beneficiary designation is not a testamentary distribution of property. It is distribution by contract. It does not have to be drawn or witnessed with the formalities required for a will, and it does not have to be admitted to probate. In paying the proceeds, the company is not, in a legal sense, distributing the insured's property but is merely paying a stated amount from its own funds not traceable to any funds received from the policyholder, and usually in excess of the amount of money paid by that policyholder.⁴³

Naming the Beneficiary. The designation of the beneficiary should be drawn so that there can be no doubt as to the exact person intended. For instance, proceeds might go to the "wrong" wife where there is both a wife and an ex-wife and the beneficiary designation was merely "wife" without indicating her name. The same situation arose when the beneficiary was designated as "Mrs. H. M. Case" rather than by her given and maiden name.⁴⁴ The accepted practice is to designate a spouse by her given and maiden name followed by her relationship with the insured, such as "Margaret Cochrun Jones, wife of the insured." "Wife of the insured" is held to be merely a description of the status of Margaret Cochrun Jones at the time of the designation and will have no effect on her right to the proceeds if she is not the wife of the insured at the time of his death.

Extreme care should be taken when children are designated as beneficiaries. If the children are designated by name, such as James Lawrence

⁴² Some policies provide that where there is no surviving beneficiary, the proceeds are payable to the person or persons who, upon proof of affidavit or other written evidence satisfactory to the company, appear to be the then living, lawful, bodily and legally adopted child or children of the insured. The proceeds are to be divided equally among two or more such persons; if there is none, they are payable to the executors or administrators of the estate of the insured.

⁴³ This may seem to be a contradiction, since it is obvious that, in an actuarial sense, there is a direct connection between the premiums paid by the policyholder and the amount of the policy proceeds, but here reference is made in terms of the legal agreement involved. A life insurance policy is not an agreement by the company to take money from the policyholder and later pay it back to his heirs. It is simply a contract with the policyholder stating that in consideration of the payment of the premium, it will pay a specified sum to his beneficiary at death.

⁴⁴ *Day v. Case* 43, Hun. 79 (1887).

Jones and Evaline Caroline Jones, children born after the designation was made will be excluded. For children, it is better to use a class designation, with the class being described as precisely as possible to avoid questions of interpretation. The general rule is that a class designation such as "children of the insured" includes all children at the time of death, but the more precise designation, "children who survive the insured," is better because it is clear that it also means a posthumous child. While this type of designation probably will be held to include adopted children, a safer designation is to state, "children of the insured, including those legally adopted" or some statement to the effect that "children" shall be defined to include adopted children. The designation, "my children," will exclude those of a spouse by a previous marriage, while "Margaret Cochrun Jones, wife of the insured, and our children" or "children of the union" will exclude all children of either spouse by a previous marriage.

In naming a class beneficiary, the owner should indicate how the proceeds are to be paid if a member of the class predeceases the insured. Suppose, for example, the insured has two children and the class beneficiary designation is "children of the insured." If one of the children dies before the insured, how are the proceeds of his policy to be distributed? In the absence of a specific policy provision to the contrary, the majority of courts hold that the surviving child is entitled to the entire proceeds since he remains as the only living member of the class.⁴⁵ Rather than leave the distribution of the insurance to the will of the court, the insured may state specifically how he wants the proceeds distributed. For example, he may name his beneficiary as follows: "The surviving children of the insured in equal shares, and to the surviving children of any deceased children of the insured, per stirpes."⁴⁶

The examples of the effect of various wordings of beneficiary designations indicate the necessity for careful consideration in naming the beneficiary.

Minor Beneficiaries. In designating children as beneficiaries, the fact that life insurance proceeds, like any other money, cannot be paid directly to a minor must be considered. Since a minor is legally incompetent to accept payments, he is also legally incompetent to issue receipts for them. To pay funds directly to a minor might subject the company to double payment. At majority, the beneficiary might bring suit to recover proceeds for which the company has

⁴⁵ A large number of courts have held that the heirs of the deceased child would be entitled to his one-half interest in the proceeds of the policy.

⁴⁶ The use of the term "per stirpes" means that the equal share of the deceased beneficiary will be divided among his children. The surviving beneficiary receives one-half in this case, and the other one-half is distributed equally to the children of the deceased beneficiary. If he has two children, each will receive one-fourth of the proceeds. If, instead of per stirpes, the designation read per capita, each child of the deceased beneficiary would share equally with the surviving beneficiary and each would collect one-third of the proceeds.

no valid receipts. Thus, where there are minor beneficiaries, a guardian might have to be appointed to accept the proceeds.⁴⁷ Another solution is for the proceeds to be held by the company, accumulated at interest until the majority of the child, and distributed at that time. While most companies will agree to this settlement plan, money left to an orphaned child in most instances is needed currently for support and education and should not be left on deposit with the company.⁴⁸ It may be desirable to name a trustee to collect the proceeds of a policy where the beneficiary would otherwise be a minor.⁴⁹

Common Disasters. A problem also arises when the insured and primary beneficiary die in a common accident with no evidence as to which died first. The burden of proof that the beneficiary outlived the insured usually is on the representative of the beneficiary since the great majority of states have adopted the Uniform Simultaneous Death Law. The law provides that if there is no evidence as to whether the insured or beneficiary died first, the policy will be settled as though the insured survived the beneficiary. The proceeds, then, would be paid to the secondary beneficiary or, in the absence of any, to the estate of the insured. These results can be accomplished in the states which do not have the Uniform Simultaneous Death Law by inserting a common disaster clause in the policy which states that if the insured and the beneficiary perish in a common accident, the presumption will be that the beneficiary died first.

Under the Uniform Simultaneous Death Law, if the beneficiary clearly survived the insured and died shortly thereafter, the proceeds would go to the beneficiary's estate. This may or may not be desirable depending on the case. If it is not desirable, then a modified common-disaster clause can be used to provide that, upon the death of the insured, the proceeds shall be held at interest for a specified period and then paid to the primary beneficiary at the end of that period, if surviving, otherwise to the secondary beneficiary (or whatever other distribution is desirable in the particular case). Settlement options, discussed in Chapter 10, frequently provide a convenient method of handling the problems arising from common disasters.

Beneficiary designations have become exceedingly complex, but the complexity is steadily reducing litigation involving them until, today the amount of such litigation is insignificant.

⁴⁷ A surviving parent is not automatically the guardian of the estate of a minor. To act in that capacity, he or she must be legally appointed as guardian by the court. Pennsylvania has a statute that allows the insured to designate a guardian in life insurance policy to receive funds for a minor beneficiary.

⁴⁸ A number of states permit waiver of guardianship and allow payments to be made to an adult for the benefit of the minor. The amount of such payments is limited, usually less than \$500. New York permits an 18-year-old beneficiary legally to receive from a life insurance company and to give a binding receipt for up to \$3,000 a year, payable by reason of death.

⁴⁹ Life insurance trusts are discussed in Chapter 17.

4. MISCELLANEOUS PROVISIONS.

In addition to the above provisions, a number of others will be found in most policies.

Policy Change. The policy may contain a provision to the effect that the insured may at any time change the policy to another form. The provision may specify the forms to which the policy may be changed. Usually change to forms requiring higher premiums and consequently higher reserve liabilities may be made without evidence of insurability; change to forms requiring lower premiums and lower reserve liabilities is subject to evidence of insurability⁵⁰ because of the possibility of adverse selection.

Policy Year. A typical clause reads, "The policy year referred to herein is the year beginning on the — of —, 19—, or any anniversary thereof." Its purpose is to define clearly the actual meaning of the term, "policy year," so that this term will be clear when it is referred to elsewhere in the policy.

Basis of Computation. A provision in the policy sets forth the basis of reserve calculation, which in ordinary policies issued today is the CSO table with an interest assumption ranging between 2 per cent and 3 per cent, commonly 2½ per cent. Additional benefits in event of accidental death or permanent and total disability are excluded from the computation. The basis of the cash value calculation also must be stated.

Modifications and Agreements. Any modification or changes in the policy and all agreements in connection with it must be endorsed on or attached to the policy in writing, and over the signature of a specified officer or officers, such as the president, vice president, secretary, assistant secretary, treasurer, or assistant treasurer. No other person has authority to make changes and agreements, to waive provisions, or to extend the time for premium payment. Some modification clauses also declare specifically that no agent has authority to make changes, waivers, or the like.

The purpose of the clause is, of course, to clarify both to the policyholder and to the courts just who has authority to alter a printed policy.

Representations and Warranties. All statements in the application shall be deemed representations and not warranties unless fraud is involved; and it is provided that no statement may be used to contest the policy or a claim unless it is in writing on the application attached to the policy. The subject of warranties and representations was discussed in Chapter 8.

⁵⁰ Change to a lower reserve form means the company will be increasing the amount-at-risk; i.e., there will be an increase in pure insurance which is defined as the difference between the face of the policy and the reserve liability charged against that policy. Hence, the insured with a health problem indicating a shortened life expectancy will be inclined to shift to a form giving him more pure insurance per premium dollar.

5. RESTRICTION OF CERTAIN HAZARDS.

Two exclusions or restrictions⁵¹ occasionally found in policies seem to merit separate discussion. One relates to aviation and the other to war.

Aviation Restriction. Restriction of coverage in case of death from aviation is universal in double indemnity provisions, occasionally found in disability provisions, but now only rarely encountered in the life insurance policy itself, except in wartime. Such wartime restrictions usually are dropped retroactively upon cessation of hostilities.

While at one time it was common in life insurance to exclude liability in all cases involving death from aviation, the increased activity in aviation over the years and its excellent safety record have resulted in the liberalization of the provision. In other words, historical developments have seen an *exclusion* change into a *restriction* and the current trend is toward the elimination of substantially all restrictions. Among the types of restrictions still occasionally found are:

(1) Exclusion of all aviation deaths except those of fare-paying passengers on regularly scheduled airlines. The exception to the exclusion has been generally extended to passengers on non-scheduled airlines as well since the experience has been favorable in this phase of aviation.

(2) Exclusion of deaths in military aircraft only.⁵²

(3) Exclusion of pilots, crew members, or student pilots (and sometimes anyone who has any duties in connection with the aircraft or the flight). The extra rate for pilots and crew members on commercial airlines has been either eliminated completely or substantially reduced in the last few years. Extra rates for private pilots also are being reduced and in some cases eliminated.

(4) Aviation death while on military maneuvers.

It should be pointed out that nearly all these restrictions can be eliminated if the insured is willing to pay an extra premium. The exclusion clauses are used only when the applicant is unwilling to pay the extra cost or where the type of aviation in which he is engaged is subject to a hazard on which the company has insufficient statistics to compute a rate.

While there was considerable litigation over the validity of aviation exclusions when they were first used, all jurisdictions now permit at least some restriction. The question of whether exclusions in the restriction were in

⁵¹ Actually, they are restrictions more than exclusions since they do cover *some* types of deaths from the so-called excluded hazards

⁵² James T. Phillips, senior vice president and chief actuary of the New York Life Insurance Company, has this to say about military aviation. "A comparison of trends in the experience as between civilian and military aviation brings out a fundamental difference which is of paramount importance in underwriting aviation risks. In civilian aviation, safety of personnel is the all-important factor and we can expect scientific advances to be directed toward making civilian flying safer in the future. Although safety is important in military flying, it must take second place to combat efficiency so that many technological developments in military aviation are likely to increase the military aviation hazard." *Insurance Lecture Series*, University of Connecticut, 1953, p. 67.

conflict with the incontestable clause has arisen, but this point now seems clearly settled. Just as in the case of the suicide exclusion, denial of a claim for an excluded hazard is not a contest of the policy but an enforcement of a policy provision. Litigation involving military aviation deaths has been undertaken on the grounds that aviation exclusions were meant to exclude only civil aviation. Courts, as a rule, have not gone along with this line of reasoning. On the other hand, the aviation exclusion was held not to apply in cases where the insured was killed by gunfire while in flight, under the interpretation that the immediate cause of the death was gunfire, not aviation. The doctrine of proximate cause, however, has been invoked to exclude deaths resulting indirectly from flying, such as drowning after a plane crash.

Some states seek to limit the extent of restrictions, such as requiring that at least fare-paying passengers on civil aircraft be covered. However, attempts of states to outlaw all restrictions or to limit them severely can result in the denial of insurance in that jurisdiction to anyone participating in aviation.⁵³

War Restriction. In wartime, companies usually insert restrictions in their contracts, generally referred to as "war clauses." These restrictions are usually contained in policies written during periods of impending war, and especially in those policies issued to young men of draft age. The clauses generally provide for a return of the premium with interest or a refund equal to the reserve valuation of the policy in event death occurs under conditions excluded in the policy.

War-caused death is a hazard not calculated in rating life insurance policies. Premiums are based on a mortality table that covers peacetime deaths only. There is no way to calculate the added mortality rate during warfare until after the war is over. Each war to date has created its own mortality rate. Further, issuance of policies without a war exclusion in time of war would result in drastic antiselection: those going into military service would be inclined to buy larger policies than they would have purchased in peacetime.⁵⁴

War clauses usually are canceled at the end of the hostilities.

Courts universally recognize that it is impossible for a private insurer to assume the added hazard of war at ordinary rates. Therefore, virtually no legal questions arise over the validity of war clauses.

⁵³ This happened in Nebraska after *State ex rel Republic National Life v. Smith*, 138 Neb. 484, 293, N.W. 373 (1940). It was necessary to pass legislation permitting exclusion of certain aviation hazards in order to alleviate the situation.

⁵⁴ After both World Wars I and II, many companies found they could have covered the war hazard without extra premium, and therefore paid war death claims retroactively despite the war exclusion clauses. The practice of paying war-incurred death has been debated on actuarial grounds. The fact that companies have found that they could have covered the hazard, however, does not mean they would have been able to do so had they issued policies without the exclusion. The exclusion tended to restrict the amount at risk to a figure small enough so that the effect of war deaths did not disturb over-all mortality experience. Had policies been issued without the restriction, antiselection might have increased the proportion of insurance on military personnel to the degree that mortality might have jumped to the point where it could have had a serious effect. The advantage of the war clause, then, seems to be in controlling adverse selection.

In general, there are two types of war clauses, usually known as the "status" type and the "result" type. One is a "while" clause and the other is an "if" clause. Under the "status" clause, liability of the company for the death of the insured is excluded *while* the insured is in military service, regardless of the cause of his death. Often this clause is liberalized to exclude only death outside the home area, as defined in the clause. The home area is usually defined as the fifty states, the District of Columbia, and Canada. Under the "result" clause, liability is excluded *if* the death is a result of war. Under the status clause, the cause of death does not matter; under the result clause, it is all-important.

Both types of clauses have given rise to endless litigation—so endless it is impossible even to summarize here.⁵⁵ The principal type of litigation, however, seems to have been over whether the wording of the clause makes it a "status" clause or a "result" clause. These cases arise, for example, when a soldier is killed in a tavern brawl or dies as a result of a common civilian disease. Unless the wording is so clear as to make the clause unquestionably a "status" clause, the courts tend to bend over backward to interpret it as a "result" clause.

Another type of litigation involves the time when a person might be said to be in military service. When the term "active service" is used, courts have excluded the period of training. In one amusing decision (amusing to us but not to the insurance company involved) a court held that the words "while on duty as a soldier" did not include a sailor who died of appendicitis while in the service. The court made a definite distinction between a soldier and a sailor, which distinction the men of the services have always insisted exists as a matter of pride in their own superior branch (whichever that might be). This decision indicates the importance of carefully spelling out to the courts just what the war clause intends to exclude. Implied intention means little to a court eager to protect the family of the serviceman.

In addition to litigation over the interpretation of the clause and the nature of the death is that over the existence of war itself. This problem arises in the time interval between enemy attack, as at Pearl Harbor, and actual declaration of war by the Congress; between the end of actual hostilities and the declaration of the end of the war; and in such situations as the Korean conflict. Multiple indemnity and disability riders almost always exclude war, acts of war, and active military service.

6. SUMMARY AND CONCLUSIONS.

The life insurance policy is a legal document setting forth the rights and obligations of the policyholder, beneficiary, and company. It is a unique contract in that all its provisions, except one, set forth the obligations of one party to the contract—the insurer. The one condition which the policy

⁵⁵ For such a summary and citations, cf. Krueger and Waggoner, eds., *op. cit.*, Chapter 18.

imposes on the insured is the periodic payment of premiums, and even here, if he defaults in his part of the contract, he cannot be held liable for its performance.

Some of the provisions of a life insurance policy are required by law. An exact list of them varies by states. Only the substance of the required provisions is set forth; the wording is left to the insurer, and any variation of the required provision that makes the policy more liberal to the policyholder is allowed. In life insurance there is no standard policy as there is, for example, in fire insurance.

Provisions often required by state law are incontestability, loan value, grace period, reinstatement, policy ownership, misstatement of age, policy to constitute the entire contract, annual participation of surplus, nonforfeiture values, and table of settlement values when offered.⁵⁶ For the most part, these required provisions are for the protection of the policyholder.

In addition to required provisions, most states prescribe a set of "permissive" provisions, i.e., provisions that need not, but may, be included. For the most part, these are for the protection of the insurer. Examples are suicide exclusion, assignment, travel and residential exclusions, policy modifications, payment of premiums, consideration, and aviation and war exclusions.

Some provisions are required, some are permitted, and some merely clarify the position of the parties. Examples of this last type of clause are the beneficiary clauses, policy year, and the like.

The interpretation of the provisions of a policy and the litigation over their interpretation and application fill volumes of law reports. The attempt in this chapter has not been to provide an exhaustive analysis or a guide to citations, but merely a summary of the major trends of interpretation and case law. For every statement made, a contrary opinion or court decision could be found, but the discussion has sought to follow the majority opinion.

In addition to the provisions discussed in this chapter are those policy provisions relating to the various policy options. These are discussed in the following chapter.

QUESTIONS FOR CLASS DISCUSSION

1. The policy issued to the insured excluded death resulting from operating any kind of aircraft. The insured was a captain in the United States Air Force, and was on duty as the pilot of a military fighter plane on a reconnaissance flight over southeastern Korea. He was shot down and died as the result of enemy gunfire. Is the company liable?
2. The insured's policy was issued on June 22, 1951, but provided that its effective date was March 14, 1951, to give the insured the benefit of a lower premium rate. It provided that the company would be liable only for return of premiums paid if the insured should commit suicide within "one year from the date of issue of this policy." The insured committed suicide on May 23,

⁵⁶ See Chapter 10.

1952, and the company denied liability for the face of the policy and admitted liability only for the return of premiums paid. The beneficiary sued for recovery of the face of policy. What should be the verdict?

3. The husband and wife each applied for "commercial whole life" policies. The husband paid the premium on his wife's policy, and the wife paid the premium on her husband's policy. Each policy provided that the payer of the premium was the absolute owner of the policy. The premium on the husband's policy was increased from \$1,767.80 (as determined by the agent) to \$1,808 60, which was not satisfactory to the applicants, and both policies were refused. Action was brought by the husband and the wife to recover the premiums paid with the applications. Can the premiums be recovered?
4. The annual premium, due on May 4, 1950, was not paid and the policy lapsed. Thereafter, the agent called on the beneficiary several times in an effort to have the policy renewed, but the beneficiary informed him he did not have the funds available. The record showed that he owned property at that time valued at \$75,000. After the policy lapsed, the insured consulted the family doctor and was referred to a specialist who diagnosed her trouble as cancer. She underwent an operation on September 7, and went home on September 10. Seven months later she died as a result of cancer. Three days after his mother returned from the hospital, the plaintiff, who was the beneficiary, told the insurance agent that he was ready to have the policy reinstated. The beneficiary could not read or write, but he answered the questions in the reinstatement application and the agent filled in the blanks with the information given him by the insured. The beneficiary's wife signed the insured's name to the application. The plaintiff testified that he did not know of the insured's illness or her hospitalization. Can the beneficiary collect?
5. After the issuance of the policy, the insured had had an operation by which over half of his stomach was removed. Thereafter, he permitted his insurance policy to lapse. In applying for the reinstatement, negative answers were made to the questions inquiring if he had consulted a physician within the last five years or had had a surgical operation or had been hospitalized. The agent testified that he asked the insured the questions in the application for reinstatement, and that he inserted the answers as given by the insured; that the insured took the application, appeared to read it over, and then signed it. Is the company liable for payment of policy face?
6. The policy was issued on August 28 and the insured died in the following May. He was taking a bath, and death may have resulted from a severe bruise on the head or from water in the lungs. The jury found that death was accidental. However, the company contended that the policy was null and void from inception because the insured had concealed a baseball injury which had caused him to have dizzy spells for some time thereafter. The beneficiary testified that the insured had told the soliciting agent (who was also the staff manager in charge of men from the company) about the injury; that he had been struck upon the head while playing baseball, and after that time he had had dizzy spells; that he had consulted doctors and had been

hospitalized; however, he had shortly before that time been examined for employment by a physician and had been passed with a favorable report. The beneficiary testified that the soliciting agent told the insured there was no need to mention the injury if he had had no trouble recently. The agent testified that he did not recall the conversation and that his memory was "hazy." The company argued that the agent's testimony should not have been admitted since the contract provided that no agent had authority to make any concessions or vary the terms of the policy. At the time the application was signed, the insured also signed an authorization permitting the company to secure any information concerning past medical attendance or advice or hospitalization. Is the company liable?

7. Some of the provisions of the typical life insurance policy are designed to protect the company whereas others are designed to protect the insured. Classify the provisions according to the parties protected.
8. John Jones has a \$1,000 continuous-premium whole life policy. His tenth annual premium is due on July 1. He fails to pay the premium and dies on July 15. How much does his beneficiary collect? Suppose he dies on August 15; how much does his beneficiary collect?
9. How do you account for the fact that the life insurance contract has been liberalized over the years?
10. If you were a banker to whom a life insurance policyholder is applying for a loan, would you rather have the policy assigned to the bank or have the bank named as the beneficiary of the policy?

CHAPTER 10

Policy Options

In addition to the general provisions of the life insurance contract discussed in Chapter 9, the policy contains provisions offering the policyholder several choices (1) in case of surrender of his policy, (2) in the method of applying policy dividends, and (3) in the method of payment of proceeds. The three types of options are called nonforfeiture options, dividend options, and settlement options.

1. NONFORFEITURE OPTIONS.

Except for short duration term policies and term policies which have expired, no policy which has been in force more than a minimum amount of time (generally one to three years) can be terminated without value. It has a value upon surrender by the insured. From almost the beginning of level-premium insurance, introduced in England by Old Equitable in 1762, at least some companies have recognized the fact that under a level-premium plan of insurance, the policyholder who surrenders his policy before maturity has contributed more than his share of premiums for the protection he has received, and deserves some type of refund.¹ Nonforfeiture values arise from three sources: (1) higher initial premiums than necessary to pay for the death protection afforded by the policy; (2) compound interest on these excess premiums at a rate guaranteed by the company; and (3) survivorship benefits for an amount determined by mortality rates guaranteed by the company.²

Early attempts at making refunds of premiums in event of termination often were confined merely to a statement that the company would give consideration to a refund in case of surrender or would "purchase back" the policy for an "equitable consideration." In 1851 the Scottish Widows' Fund and Equitable Assurance Company of Edinburgh added contract surrender values to its policies. By 1861 most United States companies had established rules for granting nonforfeiture values, and some included them in the policy as a contractual right. In 1861 Elizur Wright, member of the first Board of Insurance Commissioners of Massachusetts, effected the passage of a state law requiring extended insurance as a nonforfeiture value; and most companies

¹ This same principle was introduced in health insurance when, in 1960, Southwestern Life began offering non-cancellable, guaranteed renewable disability income policies with cash values.

² Review Chapter 1 for a refresher on the source of nonforfeiture values.

began to adopt definite forms of nonforfeiture values even when not subject to Massachusetts law. After the Armstrong investigation in New York (1905), states not yet having nonforfeiture laws generally adopted them

Life insurance policies today provide for several nonforfeiture values, any one of which may be elected by the policyholder within (usually) sixty days after the due date of any premium in default; and if no such election is made, then a stated (automatic) form of paid-up benefit becomes effective. The nonforfeiture values are guaranteed in the contract and are not subject to change, once the policy is issued.

The three most common forms of nonforfeiture options found in policies are (1) cash value, (2) reduced, paid-up insurance, and (3) extended term insurance. Because the cash value is the basis of the other two options, it will be discussed first.

Cash Value. Prior to the passage of the Standard Nonforfeiture Law, completed in most states prior to 1948, the amount of the cash value was the legal reserve required in any given policy, subject to a "surrender charge" of not more than \$25 for each \$1,000 of insurance. The purpose of the surrender charge was to enable the company to recover that part of the cost of issuing the policy which had been charged against surplus.³ Cash surrender value usually was offered only after the expiration of the first three policy years, and the surrender charge usually diminished yearly and disappeared entirely after the policy had been in force for a minimum number of years, twenty for example.

The reserve-less-surrender-charge method of figuring surrender values was subject to criticism. In the first place, the legal reserve for any policy is based on mortality and interest assumptions developed to measure the solvency of the company rather than to measure any one policyholder's equitable share in the assets of the company. The interest and mortality assumptions used for reserve computations are not usually the assumptions used in calculating premiums. Furthermore, because the legal reserve is based on mortality and interest assumptions only, it cannot reflect the incidence of expenses. This limitation made the use of a surrender charge necessary. The surrender charge itself was misunderstood and was often interpreted as a penalty for discontinuing the contract rather than as a charge for high first-year costs that otherwise would be recovered from future premiums. These criticisms, along with the desire to substitute sound actuarial principles for heretofore crude empirical standards for surrender values, led to the development and passage of the Standard Nonforfeiture Law.

³ Acquisition costs (commission to the agent, medical fee, investigation fee, all the clerical costs involved in underwriting and issuing a new policy) take so much of the first-year premium that the net amount remaining for the company is substantially less than that needed to finance the legal reserve required for the policy without drawing on surplus. The resulting charge against surplus is restored from future renewal premiums, which are greater than the amount required to offset year-by-year additions to legal reserves.

Under the Standard Nonforfeiture Law, no relationship is fixed between the cash surrender value and the reserve, and no surrender charge is made. Instead, the minimum value required is determined according to a special formula designed for that purpose. This formula fixes the maximum first-year expenses that may be charged against each type of policy at each age for purposes of determining the nonforfeiture value. This first-year expense is amortized over the premium-paying period of the policy. The formula develops an "adjusted premium" which is the net annual level premium for any given policy plus the amount sufficient to amortize the first-year expenses within the policy premium-paying period. The minimum nonforfeiture value is the present value of the company's obligations under the policy less the present value of the adjusted premiums, using actuarial assumptions yielding no less than that produced by the 1941 CSO Table at $3\frac{1}{2}$ per cent.⁴

The Standard Nonforfeiture Law does not require that a surrender value be given after any specified arbitrary period of time but instead requires that such value be given at whatever time and for whatever amount such value is produced by the formula. Thus, one policy at one age may produce a surrender value at the end of the first policy year, whereas another will not show any values for several years.⁵ The result is greater equity in nonforfeiture values than under the reserve-less-surrender-charge method of computing them. Companies can—many do—provide cash values in excess of the minimum required by law. The objective is to return to each policyholder as nearly as possible his equitable share in the assets of the company, without impairing the position of the continuing policyholders. Therefore, in developing its asset-share computations, companies take into consideration adverse selection (both mortality and financial) and the cost involved in handling the surrender.

Cash values in permanent policy forms increase yearly. Short-term policy forms have no cash values. Long-term forms may have cash values; but these values will increase up to a point, thereafter declining to zero on the expiry date of the policy.

In Table 12 are typical examples of cash values on several policy anniversaries for selected ages of issue.

The purchase of life insurance policies with cash values is one way of creating emergency funds. These values may be withdrawn in cash, taken as a policy loan, or used as collateral for a bank loan. However, drawing on other types of savings, if available, may often be more advantageous. Withdrawal of life insurance cash values necessitates terminating the contract, which might be impossible to replace later. Taking the value as a policy loan means paying the insurance company a higher rate of interest than the cash value earns un-

⁴ If this paragraph is not clear, then try it again after reading Chapter 23.

⁵ The Nonforfeiture Law does not require a cash value until the end of three years. Values developed prior to that time need be only some form of paid-up insurance benefit, the form of which is to be left up to the company. This paid-up benefit is to be automatic if none of the options is elected within sixty days after the due date of the premium in default.

TABLE 12.

Continuous-Premium Whole Life (\$10,000 Minimum)

Cash Value per \$1,000 of Face, CSO 2½%, Participating

<i>End of Policy Year</i>	<i>Age at Issue</i>		
	20	30	40
1	\$ 0	\$ 0	\$ 0
2	0	2	12
3	7	19	34
5	33	52	77
10	103	141	189
20	248	322	407
At age 65	628	580	505

20-Pay Life

Cash Value per \$1,000 of Face, CSO 2½%, Participating

<i>End of Policy Year</i>	<i>Age at Issue</i>		
	20	30	40
1	\$ 0	\$ 0	\$ 1
2	14	23	32
3	37	50	64
5	84	106	129
10	211	257	304
20	503	603	705
At age 65	754	754	754

20-Year Endowment

Cash Value per \$1,000 of Face, CSO 2½%, Participating

<i>End of Policy Year</i>	<i>Age at Issue</i>		
	20	30	40
1	\$ 11	\$ 11	\$ 11
2	52	52	52
3	94	94	94
5	182	182	181
10	423	421	418
20	1,000	1,000	1,000

der the policy. While bank loan rates in times of free credit might be a point or two lower than the rate for policy loans, they might still be higher than the rate credited to the policyholder under the policy. On the other hand, the cost of drawing funds from other saving media is the loss of interest they would have earned if left intact. Since the interest rate on most such media used by the typical person is usually low (only 3 per cent or so on bank savings accounts, for instance, as compared with 5 per cent to 6 per cent on policy or bank

loans), the cost of emergency funds drawn from sources other than life insurance cash values will usually prove less.⁶

Perhaps the more important use of life insurance cash values is as a vehicle for building a retirement fund that can be paid to the insured as an annuity upon retirement. Sometimes the option to take cash values as an annuity is written into the policy, whereas at other times these options are granted as "company practice." A knowledge of life insurance cash values is essential in the development of a sound life insurance program.

When reference is made to the "savings"⁷ or "investment" element in a life insurance policy, the cash values actually are what is meant.

Paid-up for a Reduced Amount. Reduced, paid-up insurance is the nonforfeiture value used by some companies as automatic if no option is elected by the insured within sixty days after the due date of the defaulted premium.⁸ In these companies, if the policyholder fails to pay his premium and makes no overtures to the company about the disposal of his policy, the company automatically applies the paid-up, reduced amount option.⁹

In the case of the reduced, paid-up insurance nonforfeiture option, the company applies the *net* cash value available under the policy at the time of default to the purchase of whatever amount of fully paid-up insurance it will buy, at the net single-premium rate at the insured's attained age, on the same plan as that of the original policy. Thus the paid-up insurance under a whole life policy will be, of course, whole life, and will be endowment under that type of contract. The *net* cash value is the cash value for the face amount at the date of default, increased by the cash value of any dividend additions and the amount of any dividend accumulations and decreased by the amount of any indebtedness to the company against the policy. The examples in Table 13 show the amounts of paid-up insurance available at the end of given policy years based on several ages of entry on three policy plans, assuming no dividend additions, accumulations, or policy indebtedness.

The paid-up option should be elected when the policyholder's need for insurance protection has decreased but will continue to exist until the maturity date of the policy. For instance, at age 65 financial protection against death

⁶ This is not intended as an argument against life insurance but as an argument for keeping life insurance policies unencumbered and building one's primary emergency reserves through savings media other than life insurance.

⁷ New York law prohibits referring to a cash value as "savings," a sound technical but hair-splitting distinction from a practical standpoint.

⁸ Because of the small death benefits that can be involved under this option, it is not common to use this as the automatic option.

⁹ It is not widely understood by policyholders that even if they do nothing after failing to pay a premium, some value will continue in force for some time thereafter—provided there was a paid-up value under the nonforfeiture valuation formula at the time. Cases are not uncommon of beneficiaries who discovered long after the death of the insured that the old policy on which premiums had not been paid for years was still in force for some value at the death of the policyholder. The beneficiary should never discard a lapsed policy found among the effects of the deceased, but instead should check with the company to see if it still has value.

TABLE 13.

Special Continuous-Premium Whole Life (\$10,000 Minimum)

Paid-Up Values per \$1,000 of Face, 1941 CSO $2\frac{1}{2}\%$
Participating

<i>End of Policy Year</i>	<i>Age at Issue</i>			
	20	30	40	50
1	\$ 0	\$ 0	\$ 0	\$ 0
2	0	5	23	42
3	20	44	64	84
5	89	141	140	168
10	249	281	315	360
20	494	535	578	621

20-Pay Life

Paid-Up Values per \$1,000 of Face, 1941 CSO $2\frac{1}{2}\%$
Participating

<i>End of Policy Year</i>	<i>Age at Issue</i>			
	20	30	40	50
1	\$ 0	\$ 0	\$ 2	\$ 10
2	40	54	62	68
3	103	114	121	124
5	225	233	234	233
10	510	512	505	490
20	1,000	1,000	1,000	1,000

20-Year Endowment

Paid-Up Values per \$1,000 of Face, 1941 CSO $2\frac{1}{2}\%$
Participating

<i>End of Policy Year</i>	<i>Age at Issue</i>			
	20	30	40	50
1	\$ 18	\$ 18	\$ 17	\$ 17
2	80	80	78	77
3	142	141	138	134
5	261	260	254	246
10	539	535	526	508
19	960	959	957	950

is still needed for at least final expenses. If the policyholder has in force more death protection at retirement than he feels will be needed to pay the cost of dying (funeral expenses, taxes, etc.), he can convert some of the insurance to the reduced, paid-up insurance option, making it unnecessary to continue premium payments and allowing him to spend his entire retirement income for the costs of living.¹⁰

¹⁰ If he does not need all of the reduced paid up insurance available, he can take the cash values of some of his insurance as a retirement income

Reduced, paid-up insurance continues to pay dividends if the original policy was participating. The reduced, paid-up option is not available under term insurance contracts.

Extended Term. The extended term option is more commonly used as the automatic option in the event that the policyholder fails to elect one of the other two nonforfeiture provisions within the required time. Under this option the company converts the policy into single-premium term insurance for the full face of the policy (less any policy loans outstanding) for a period as long as the net cash value will purchase, when applied as a net single premium at the insured's age at time of default. "Net cash value" means that any policy loans are deducted from and dividends added to the cash values as listed in the policy.

In the case of endowment policies, if the cash value will extend the term beyond the maturity date, the amount of net cash value in excess of that needed to continue the face amount to maturity will be used to purchase pure endowment; i.e., endowment payable only if the policyholder lives to the endowment date. In other words, if a \$1,000 endowment policy with five years to run to maturity is placed on an extended term option, it will be handled as follows: First, assume the cash value of this particular policy is \$567.41 and that the amount required for a net single premium for a \$1,000 term policy for five years at the age of surrender is only \$54.63. The \$512.78 remainder would be used to purchase a pure endowment. The amount of five-year pure endowment that can be purchased at the policyholder's attained age with a net single premium of \$512.78 is \$616.48. If under this option the insured dies within five years, his beneficiary will collect \$1,000 (the amount of the extended term insurance); however, if he lives for five years, he will collect \$616.48 (the amount of the pure endowment).

Under extended term, the full amount of the policy (assuming no accumulated dividends or policy indebtedness) remains in force for a limited period of time instead of (as in the reduced amount option) a reduced amount of insurance remaining in force for the full policy period.

Table 14 shows the length of time each of several policies will remain in force at full value, assuming given ages of issue, if these policies are put on the extended term option at the end of the policy years indicated and no dividend credits or policy indebtedness are involved.

Handling a Policy Loan. When there is a loan outstanding against a policy that is to be continued as extended term insurance, it is deducted both from the face of the policy and from the cash value. This means that a smaller amount of insurance is extended for a period shorter than would be the case had there been no indebtedness. Were the loan deducted from the cash value only, the policy would be extended for even a shorter period.

Assume a \$10,000 policy issued at age 25 which has been in force twenty years on the continuous-premium whole life basis. Assume further that the policy has indebtedness against it for \$1,000, and that the policyholder decides

TABLE 14.

Special Continuous-Premium Whole Life (\$10,000 Minimum)

Extended Term Durations per \$1,000 of Face, 1941 CSO
2½%, Participating

End of Policy Year	20		Age at Issue 30		40	
	Years	Days	Years	Days	Years	Days
1		0		0		0
2		0		192	1	265
3	2	242	4	187	4	132
5	10	308	10	28	8	9
10	21	273	17	86	12	260
20	25	303	19	244	14	20
At age 65	17	172	15	215	13	43

20-Pay Life

Extended Term Durations per \$1,000 of Face, 1941 CSO
2½%, Participating

End of Policy Year	20		Age at Issue 30		40	
	Years	Days	Years	Days	Years	Days
1		0		0		57
2	5	162	5	247	4	142
3	13	2	10	287	7	258
5	23	36	17	278	12	130
10	34	209	26	177	18	277
20	Paid-up		Paid-up		Paid-up	

20-Year Endowment

Extended Term Durations and Pure Endowment ^a per \$1,000
of Face 1941 CSO 2½%, Participating

End of Policy Year	20			Age at Issue 30			40		
	Years	Days	Pure En- dowment	Years	Days	Pure En- dowment	Years	Days	Pure En- dowment
1	4	164	\$ 0	2	351	\$ 0	1	251	\$ 0
2	18	0	1	11	259	0	6	299	0
3	17	0	71	17	0	11	10	248	0
5	15	0	207	15	0	158	15	0	30
10	10	0	515	10	0	489	10	0	423
19	1	0	960	1	0	958	1	0	956

^a The amount of endowment to which the insured will be entitled if living on the maturity date. Under the extended term option, the amount of death protection remains the same as long as the extended term runs, but the amount of endowment payable is lower than it would be if the premiums were continued to the maturity date.

to discontinue premium payments, forget the loan, and put the insurance on the extended term, nonforfeiture option. A twenty-year-old continuous-pre-

mium whole life policy of \$10,000 issued at age 25 in a typical company has a cash value of about \$2,840. When this policy is placed on the extended term basis, the loan is subtracted from both the face amount and the cash value of the policy. Thus, this policy will extend \$9,000 for as many years as \$1,840 will provide at the net single premium for term insurance at the attained age (45).

At first glance it might seem unfair to subtract the amount of the loan from both the face amount and the cash value of the policy. On closer examination, however, the logic of this procedure becomes apparent. If the amount of the indebtedness were not subtracted from the face amount of the insurance when the policy is put on an extended term basis, the result could be adverse selection, making it profitable for everyone to borrow heavily on his policy when he reaches his deathbed, and then surrender it for extended term insurance for its full amount. The effect would be to increase the insurance, contrary to all good underwriting practices.

Suppose that shortly after he borrows the \$1,000, the insured in the above case decides to cash in his policy for its cash value. He will be entitled to collect only \$1,840, since he has already received \$1,000. Suppose, instead of cashing in the policy, he dies shortly after getting the loan. His beneficiaries will collect only \$9,000, since the face of the policy as well as its cash value is encumbered by the loan. If he neither dies nor cashes in his policy but instead converts it to an extended term contract, his present insurance (in this case \$9,000) is continued for the period purchased by the remaining cash value (in this case \$1,840). Therefore, the insured gets full value—the adjustment in the amount of the term extended does not impose any penalty on him. The situation is just the reverse when there are dividend accumulations. The amount of the accumulations is added to the face amount of the term extended and to the cash value used as the net single premium. This seemingly double adjustment upward does not impose any penalty on the company.

Although the general practice is to convert participating policies to a nonparticipating basis when placed on extended term, some companies continue the participating feature.

When a policyholder no longer can continue premium payments and yet wishes to keep insurance in force, he must choose between reduced, paid-up insurance and extended term insurance. If the policyholder is in good health and needs permanent protection, obviously he will select reduced, paid-up insurance. This is true especially if the policy has a large cash value, since the larger the cash value, the smaller will be the reduction in the amount of insurance. If, on the other hand, the policyholder is in poor health or has a temporary insurance need, he will be inclined to select the extended term option.

If for some temporary reason, premiums cannot be paid out of current funds, they should be paid with a premium loan until the temporary financial embarrassment has passed. If one of the paid-up insurance nonforfeiture options is selected, the policyholder may never be able to replace his policy with one as good as the one surrendered. Another important reason for using a

premium loan rather than one of the nonforfeiture options is that any disability provisions are kept in effect. Double indemnity and disability income riders terminate upon conversion to reduced, paid-up, or extended term.

2. DIVIDEND OPTIONS.

Life insurance policies may be issued on either a participating or a non-participating plan.¹¹ Under the participating plan, policyholders are entitled to policy dividends as declared by the company. These dividends reflect the difference between the premium charged for a given class of policies and the actual cost of these policies as experienced by the company. Under the non-participating plan, policies are written for a premium lower than the gross premium on participating insurance.

The Nature of Dividends. Dividends distributed to participating policyholders are not profits in a commercial sense, but instead are a return of an overcharge of premium.¹² That portion of the company's earnings for the year not deemed necessary to strengthen surplus or contingency reserves may be distributed among individual policyholders.¹³ The method of calculating dividends is rarely if ever stated in the policy contract. Instead, the policy makes some such statement as, "This policy, on each anniversary while in force, except as extended term insurance, shall participate in the divisible surplus of the company, but payment of the first dividend shall be contingent upon and proportionate to the premiums due and paid for the second policy year. The company will annually determine the dividends of such surplus apportionable to this policy."¹⁴

The dividend clause often includes a provision for the payment of dividends for the fraction of the policy year in which the policyholder dies. The practice on such post-mortem dividends varies from full payment of the current year's dividend to a pro rata share. No fractional dividends, however, are paid upon surrender of the policy.

Participating policies offer the policyholder the choice of several methods

¹¹ For a more complete discussion and analysis of participating and nonparticipating plans, as well as of mutual and stock companies, cf. Chapter 24.

¹² See Chapter 17 for a discussion of tax laws relating to policy dividends.

¹³ Cf. Chapter 23 for a discussion of the source of surplus and the problems involved in its apportionment.

¹⁴ Annual distribution of policy dividends is required by the laws of many states, particularly New York, where the system of deferred dividends popular in the late nineteenth and early twentieth century led to abuses castigated by the Armstrong Committee. Cf. Chapter 26. Even where not required, the practice of annual policy dividends is usually followed. However, dividends paid over longer periods, quinquennially, for example, are not unknown and have their sincere advocates. Under the laws of New York and those of a number of other states, dividends are not restricted exclusively to regular annual payments. Extra dividends at reasonable intervals or dividends on policy terminations are allowed. Extra and terminal dividends, however, are carefully supervised by the insurance regulatory departments of the states in order to prevent a disproportionate amount of funds from being used for these types of dividends. In general, these special dividends must not be too large in comparison with the regular annual dividends apportioned on the policies in preceding years, otherwise they will be declared inequitable.

of receiving these annual refunds. The common dividend options are (1) to pay in cash, (2) to apply toward the payment of the premium, (3) to leave to accumulate with interest credited annually at a guaranteed minimum rate of interest, (4) to use to buy paid-up additions to the policy, (5) to use to convert a whole life policy to an endowment (or shorten the endowment period), (6) to use to pay up the policy in fewer than the contract years, and (7) to use to buy one-year term insurance. The automatic option varies among companies, being cash in some companies, the accumulation option in others, and the paid-up addition option in still others. Some states specify the dividend option that is to be automatic if no other is selected by the policyholder.

Payment in Cash. About 20 per cent of all policy dividends are taken in cash. The cash dividend option is used most frequently when the policy is paid up. Unless there is some particular reason why the policyholder wants the dividend in cash, he should weigh the advantages of the other options before making his selection. A situation in which the cash dividend option might be attractive is while the premiums are being waived for permanent and total disability under the waiver-of-premium clause. The dividends might provide a source of some badly needed cash.

Application Toward Payment of Premiums. Over 30 per cent of all policy dividends are used as part payment of premiums. Usually, the company's premium notice will show the gross premium, the amount of the dividend, and the net premium due. The policyholder has only to send his check for the net premium, which, together with the dividend, will take care of the premium due for that period. In order to afford a reasonable life insurance program, many families must depend on policy dividends to help meet their premium obligations.

Accumulation at Interest. At the option of the policyholder, dividends will be retained by the company and accumulated at not less than a guaranteed rate of interest specified in the policy, compounded annually. If the company earns more than the guaranteed rate, the dividend deposits may participate in the excess earnings.

Companies may include in the contract a provision automatically applying accumulated dividends at the expiration of any grace period to the settlement of any past due premiums, if the accumulated dividends are sufficient for that purpose. If the dividend accumulations are insufficient to meet the full annual premium, they may be used automatically to pay the corresponding quarterly, semi-annual, or monthly premium but never to pay a fraction of these premiums.¹⁵

If the dividends are not withdrawn (and, assuming the type of provision

¹⁵ Practice in the application of dividend accumulation varies from contract to contract. However, in at least one case (*Indianapolis Life v. Powell*, 104 S.W. (2d) 157 (Tex. Civ. App. 1937)), it has been held the obligation of the company to apply any dividends it holds to premium payment even though the policy provided that "no premiums shall be construed as paid, either wholly or in part, by reason of dividends remaining with the company under the accumulation option."

mentioned in the preceding paragraph, are insufficient to pay a full premium), they may be applied to increase the period of time for which the policy will be continued in force under the extended term insurance, nonforfeiture provisions.

The contract also usually provides that dividend accumulations may be withdrawn at any time provided they have not been applied under a nonforfeiture option.

If dividend accumulations are neither withdrawn, used for premium payments, nor applied under a nonforfeiture option, they will be included in the cash settlement made at the time the policy matures as a death or endowment claim or upon the surrender of the policy.

Dividends left to accumulate can amount to a rather sizable sum over a period of time. For example, although present dividend and interest scales are not guaranteed for the future, in one representative company, dividends left to accumulate under a \$10,000 continuous-premium whole life policy issued today at age 35 would, at age 65, add \$3,936 to the \$5,468 guaranteed cash values in the policy. In terms of retirement income, the dividend accumulations would increase the guaranteed monthly life income from \$33.70 to \$57.90 (male), 120 months certain. Dividend accumulations, therefore, can substantially increase the retirement values in an insurance program. Over 30 per cent of all current policy dividends are left to accumulate at interest.

Paid-up Additions. The policy usually provides that, upon the election of the policyholder, dividends may be applied to the purchase of additional paid-up participating insurance of the same type, usually referred to as "dividend additions." This option usually is not available with term insurance. Providing insurance at net single-premium rates, these options represent the least expensive way a policyholder can purchase insurance, since no charge for expenses is added to the rate.¹⁶ For example, the gross rate at age 28 for a \$1,000 single-premium whole life policy in one representative company is \$466.58, over 46 per cent of the face of the policy. In this same company, a policy dividend of \$1.00 at age 28 will buy \$2 51 of paid-up insurance. The effective rate here is only about 40 per cent of the amount of insurance, since it is the *net* rather than the *gross* rate. These paid-up additions are generally eligible for future dividends along with the original contract, but at a lower rate because, purchased at net rates, they do not participate in expense savings. About 18 per cent of the dividends currently being apportioned are used to add insurance. Table 15 indicates the amount of paid-up insurance purchased in a representative company by a cash dividend of \$1.00 at the ages given for whole life and for endowment at age 65.¹⁷

Over a period of years, paid-up additions can produce a substantial

¹⁶ "Net rate" used here means gross rate less cost of operation and should not be confused with the same term used to designate gross rate less dividend.

¹⁷ Rates will vary from company to company. The above is based on 1941 CSO at 2½ per cent interest.

TABLE 15.

**Amount of Paid-up Insurance Purchased by a Cash Dividend
of \$1.00 (Whole Life and Endowment)**

<i>Attained Age</i>	<i>Whole Life</i>	<i>Endowment at Age 65</i>
20	\$2 95	\$2 58
25	2 67	2 32
30	2 42	2 09
35	2 19	1 88
40	1 99	1.70
45	1 81	1.53
50	1 66	1 38
55	1 53	1 25
60	1 42	1 12

amount of insurance. For example, if dividends on a \$20,000 continuous-premium whole life policy issued at age 45 were used to buy paid-up additions, by age 65, the amount of additional paid-up insurance purchased by the insured under one company's *present* dividend scale would amount to \$4,840.

Companies usually provide that the paid-up additions may be surrendered at any time for a cash surrender value equal to the full reserve value thereof, which will always equal or exceed the amount of the dividends used to purchase the additions.

Occasionally, companies require evidence of insurability if the paid-up option is elected after the policy has been in force for a period of time. The practice is an attempt to eliminate adverse selection in the use of the option.

The Endowment Option. The endowment option may be found in two forms. Under the most common form, dividends remain as an accumulation until they, plus the cash value, equal the face, at which time the policy upon request is paid as an endowment. Under this plan, if death occurs before these values equal the face amount, both the face amount and the dividend accumulations are paid to the beneficiary. For example, the \$20,000 continuous-premium whole life policy issued at age 45 discussed above could mature as an endowment at age 75 if dividends were left to accumulate at interest, assuming of course no changes in the dividend scale and interest rates. At age 75 the cash value of the policy plus the value of the accumulated dividends equals \$20,000. If the policyholder under this plan dies before age 75, his estate collects both the policy face and the accumulated dividends.

Under the less common form, the dividends are used each year to shorten the endowment period by adding them directly to the policy reserve.¹⁸ The effect is to change the policy form each year by reducing its term. With this plan, the policy will endow earlier than it will under the other plan because the policy reserve will reach the face amount of the insurance sooner. This is be-

¹⁸ This is an expression of convenience. Actuarially, there is no reserve per policy but only the total reserve for all policies.

cause of the fact that as each dividend is paid, the reserve is increased, reducing the amount-at-risk.¹⁹ With less at risk, a smaller proportion of the future premiums to be collected will be needed than originally anticipated to pay the cost of insurance and therefore more can be used to build the reserve.²⁰ Thus, the continuous-premium whole life policy discussed above could mature as an endowment earlier than at age 75 with this option, sometimes called the accelerative endowment plan. Death benefits under the accelerative plan are limited to the face amount of the policy since the dividends have been added to the policy reserve.

The Paid-Up Option. If the dividends are used to buy paid-up additions or are left to accumulate at interest, when the cash value of the policy plus the accumulations (or cash value of the additions) equals the net single premium for a paid-up policy of the same amount at the attained age of the insured, the policy will (upon request) be endorsed as fully paid up. For example, the above \$20,000 continuous-premium whole life policy issued at age 45 could be paid up at age 69 if the paid-up option were exercised, assuming, of course, no change in the dividend scale or interest rates. If the insured dies before age 69, his estate collects the face of the policy plus the dividends. At age 69 the cash value of the policy plus dividend accumulations equals \$15,812, the net single premium for a \$20,000 whole life policy at that age. The policy could be paid up even earlier if the insured elects the paid-up option when the policy is issued. In this case the dividends are credited directly to cash values rather than accumulated separately at interest. In this event, if the insured dies early, his estate collects only the face amount of the insurance. This latter variation operates in the same way as the similar variation discussed in connection with the accelerative endowment.

The application of either of these optional methods of paying up the policy saves the policyholder the loading costs allocated to the remaining premiums, which no longer have to be paid.

One-Year Term Option. Some companies include the option to purchase additional one-year term insurance with the dividends. The term is usually written in the amount of the cash value of the policy. When the dividend is not sufficient to purchase this amount of insurance, the option is terminated. For example, on a continuous-premium whole life policy issued at age 35, the termination date in one company will not be reached until the forty-second policy year when the insured is aged 77. If the option is not selected at the time the policy is issued, evidence of insurability will be required if it is selected later. Any excess over the amount of the dividend used to purchase term insurance will be paid under any of the other options discussed above. The term option is the newest option and is gradually being included in more and more

¹⁹ The amount-at-risk has been defined here as the face of the policy less the reserve

²⁰ While this point could be explained in terms of the survivorship benefit concept, it is easier to understand in terms of the decreasing-insurance-increasing-investment concept.

TABLE 16

Example of Term Dividend Option
Age 35; Plan, Ordinary Life; Amount, \$100,000; Yearly
Premium, \$2,438

<i>Year</i>	<i>Guaranteed Cash Value End of Year (1)</i>	<i>Dividend at End of Previous Year (2)</i>	<i>Cost of One- Year Term Additions (3)</i>	<i>Acc Divs Beg of Year After Pur- chase of Term (4)</i>	<i>Term Additions Purchased Beg of Year (5)</i>	<i>Com- bined Death Benefit ^a (6)</i>
1	\$ 200	\$ 0	\$ 0	\$ 0	\$ 0	\$100,000
2	2,100	263	6	257	2,100	102,357
3	4,100	311	13	563	4,100	104,663
4	6,000	360	20	921	6,000	106,921
5	8,000	408	28	1,331	8,000	109,331
6	9,900	457	38	1,793	9,900	111,693
7	11,900	499	50	2,300	11,900	114,200
8	14,000	542	63	2,854	14,000	116,854
9	16,000	584	78	3,453	16,000	119,453
10	18,100	627	95	4,097	18,100	122,197
15	27,600	825	219	7,930	27,600	135,530
20	37,200	1,011	453	12,451	37,200	149,651
25	46,600	1,184	877	16,912	46,600	163,512
30	55,700	1,341	1,617	19,822	55,700	175,522

^a Includes accumulated dividends. The death benefit will be increased by any post-mortem dividend payable and by interest on accumulated dividends from the preceding policy anniversary to the date of death.

Notes. This illustration is applicable only to a standard policy with premiums paid yearly.

The forty-second policy year is the last year for which the accumulated dividend fund is sufficient to purchase one-year term additions equal to the full guaranteed cash value.

The illustrative dividend results and the premiums which determine the costs of one-year term additions are based on the scales in use in 1959 by the company used for this illustration.

policies. An illustration of the operation of the term dividend option is found in Table 16.

Which Dividend Option to Select. The solution to the problem of selecting a dividend option is by no means cut and dried, although several guideposts may be established.

If the policyholder is operating on a tight budget, perhaps the only choice he has is to take his dividends in cash or use them to pay premiums. If, on the other hand, he can afford to select one of the other options, he has to make a choice among paid-up additions, accumulations at interest, the accelerative option, and in some cases the one-year term option. If he feels that it is more important that he increase his death protection than his retirement protection, paid-up additions are the proper choice, assuming, of course, that the term insurance option is not available. Paid-up additions will increase both death and retirement protection but will increase death protection more.

If the need for retirement protection is greater, then the accelerative option is the proper choice. Under this option, there is no increase in death protection whatsoever, because the dividends are used to increase cash values. Only the face of the policy will be paid upon death of the insured.

The accumulations-at-interest option, frequently called the deposit option, seems to stand between the accelerative option and the paid-up additions option. It offers more death protection but less retirement protection than the accelerative option and more retirement protection but less death protection than the paid-up additions option.

The cash value of paid-up additions in many cases will not be much less than the value of dividend accumulations. Thus, the insured can have the benefit of increased protection through the years and then cash in his additions at age 65, if he so desires, and still have nearly the same amount of cash as if he had left the dividends to accumulate.

Since interest credited under dividend accumulations subject to withdrawal is taxable in the year credited, paid-up additions or the accelerative option might offer the best possibilities where a tax problem is involved.

At age 65 on the continuous-premium whole life policy of one company, for an illustration of the above point, the cash value of the accumulations based on a twenty-year projection of its current dividend scale and current interest rate would be \$3,035.80 for a \$10,000 policy issued at age 45. The cash value of paid-up additions would be \$2,950.60, or just 2.9 per cent less. When it is held in mind that interest on dividends left to accumulate is taxable in the year credited, whereas the increase in the cash values of the additions is not, the net value to the policy owner of the additions is nearly always in excess of that of the accumulations, in spite of the fact that the former had also provided what, solely from the point of view of this comparison, can be considered as "free" insurance.

Several circumstances make the selection of the one-year term option useful where it is available. If the death protection is inadequate, the one-year term option provides a method of increasing the protection at a faster rate than under the paid-up additions option. If the cash value is used as collateral for a loan, the one-year term option can retain the face amount of the insurance as death protection. The one-year term insurance equal to the cash value of the policy offsets the indebtedness. In any situation in which the cash value is encumbered, the one-year term option offers relief.

3. OPTIONAL METHODS OF SETTLEMENT.

An important purpose of life insurance is to provide an income for the beneficiaries upon the death of the insured, or for the insured himself in old age. In keeping with this thought, life insurance companies have developed a number of income options which are included in most life insurance policies. One of these options may be elected either by the policy owner while living or by the beneficiary after the policy owner's death, if none has been elected prior

to that time. The election by the policyholder naturally takes precedence unless a choice to change is left to the beneficiary.

The proceeds of the policy at maturity are paid to the beneficiary or policyholder in a lump sum, unless some other plan of settlement agreement is chosen.²¹ The policy contract of one company states the matter thus:

(a) *By Insured.* The Insured shall have the right, with the privilege of change before this Policy becomes payable, to elect payment of the net proceeds payable by reason of the death of the Insured under one or more of the Settlement Options described below.

If this Policy provides for maturity as an endowment or for surrender for cash, upon such maturity or surrender one or more of the Settlement Options shall then be available for payment of the net proceeds to the Insured as Direct Beneficiary. The Insured may, with the privilege of change, designate one or more Contingent Beneficiaries under the election.

(b) *By Direct Beneficiary.* If no election is in force when this Policy becomes payable by reason of the death of the Insured, a Direct Beneficiary, in lieu of payment in one sum, may then make the election, except that Option E²² may be elected only by two Direct Beneficiaries. Upon any such election, the interest of any Contingent Beneficiary designated by the Insured shall terminate. The Direct Beneficiary may then, with the privilege of change, designate one or more Contingent Beneficiaries under such election.

(c) *Limitation as to Availability.* Except with the consent of the Company, the Settlement Options shall not be available to any Direct or Contingent Beneficiary not a natural person taking benefit in his or her own right, or to any assignee.

If the net proceeds of this policy shall be less than \$1,000, or if the performance of an election would result in periodical payments less than \$10, the Company may deem the election ineffective and pay the proceeds or the then commuted value in one sum.

(d) *Endorsement.* No election, designation, direction, revocation, or change shall be effective unless duly made in writing and until filed at the Home Office accompanied by this Policy for endorsement.

The most common optional modes of settlement offered by policy contracts are as follows:²³

Interest Only. Under the interest-only option, sometimes called the "deposit option" because it resembles money on deposit in a bank, the company holds all or a part of the proceeds or cash values and pays the beneficiary or the insured a contractually guaranteed rate of interest or a higher rate as may be determined annually by the company in view of its earnings. The policyholder may provide, if he wishes, that no part of the principal sum shall ever be withdrawn by the primary beneficiary, being payable to a secondary bene-

²¹ Except in family income, family maintenance, or other policies where the insuring clause agrees to pay an income of so much a month for a stated period or to a stated date, before the lump sum is payable.

²² Joint and last survivorship.

²³ About 75 per cent of all ordinary and 90 per cent of all group death benefits in a typical year are paid in a lump sum.

ficiary or to the estate of either the beneficiary or policyholder upon death of the primary beneficiary.²⁴

The policyholder may, on the other hand, direct that the proceeds be held at interest with the right of the beneficiary to withdraw in whole or in part. For example, a policyholder might direct that proceeds from a \$20,000 policy be held at interest only, with the guaranteed or earned interest payments payable to his widow as long as she shall live, but granting her the right to withdraw principal amounts not to exceed \$500 in any one year. An important use of the interest-only settlement with the privilege of partial withdrawal is to provide an emergency fund for the widow that she may use in case there are unexpected expenses beyond her income for the year. The withdrawal of any part of the principal sum will, of course, reduce subsequent interest payments. The policy might also provide for the withdrawal of the full \$20,000 without any restrictions.

Another use of the interest-only option with right of full withdrawal is to create an estate clearance fund which will be needed soon after but not immediately upon the death of the insured. The interest-only option is more appropriate than the lump sum settlement for this purpose, since the fund will earn interest until a withdrawal is made. The policyholder also could direct that at his death the policy proceeds shall be held at interest until named children have reached a specified age.

Varied uses of the interest-only option can be worked out. The option may be used economically when the proceeds are very large. In the case of \$200,000 of insurance, the 2½ per cent interest option will guarantee at least \$5,000 a year, which is likely to be sufficient, especially if there is Social Security or other estate income.

The interest-only option is used also in insurance planning when there is reason to defer the payment of the policy proceeds to a later date. A common period for deferral is to the end of the widow's Social Security dependency income. As soon as the youngest child reaches age 18, the widow's Social Security income terminates until she reaches age 62. A \$10,000 policy purchased to offset the loss of this Social Security income may be held at interest after the insured's death until it is needed. A few companies will agree to accumulate the interest payments, too, at compound interest until needed; but most companies require the beneficiary to take the interest payments in cash. Many companies, however, will accumulate the interest during the period of the minority of a beneficiary.

Another reason for deferral is to take advantage of higher interest guarantees on older policies. Many policies issued before the mid-1930's guarantee

²⁴ Many companies hesitate to agree to pay any remaining proceeds back to the estate of the policyholder, as contrasted to payment to the estate of the last surviving beneficiary. Payment to the estate of the insured may necessitate reopening that estate half a century or more after the policyholder's death. Moreover, such an arrangement can be a factor in disqualifying the proceeds for the federal estate tax marital deduction. State laws on perpetuities also could be involved.

3 per cent to $3\frac{1}{2}$ per cent. Policies issued in the mid-1940's guarantee $2\frac{1}{2}$ to 3 per cent. Policies issued today guarantee only 2 per cent to $2\frac{1}{2}$ per cent.²⁵ Newer policies should be used to meet the need for income over the first few years, and older policies deferred for use in providing the income thereafter. These older policies may be placed on the interest-only option until they are ready for liquidation under one of the other options.

The older policies not only carry higher interest guarantees but also assume mortality experience more favorable to the annuitant. Thus, the newer policies would be better for fixed-period income needs, while the older policies would be preferable for providing lifetime income. The face amount of the policy could be kept intact under the interest-only option until the newer policies are liquidated and then be placed on a lifetime-income option. In this way, the beneficiary can obtain the greatest value from these guarantees. Unfortunately, however, some companies do not allow a beneficiary to use the interest-only option for a number of years and then change to a lifetime-income option at guaranteed rates. In these companies, such changes can be made only at the rates then current.²⁶

Installment for Fixed Period. Under the installment-for-fixed-period option—sometimes called the “installment certain” or “time option”—the proceeds are retained by the company and paid in equal installments over a specified number of months or years.

The fixed-period installment option provides that the proceeds will be held by the company and paid in equal annual, semi-annual, quarterly, or monthly installments, including both principal and interest, for a definite number of years, regardless of the life of the beneficiary. Upon the death of the primary beneficiary, the payments either are continued to a secondary beneficiary or their commuted value is paid to the beneficiary's estate.

Under this fixed-installment option, the length of the income period selected determines the amount of each installment. Interest on unpaid proceeds is based on a rate specified in the policy, with excess interest allowed when earned. Because under this option the principal sum is gradually paid out along with interest, the amount of each guaranteed installment is increased by the excess interest earnings only on the remaining principal. The actual amount paid in each installment under participating options, therefore, might well decrease gradually as the principal decreases, even though the rate of interest paid remains unchanged.

²⁵ Whereas many companies guarantee only 2 per cent or $2\frac{1}{2}$ per cent, they are paying higher rates in practice—some over 3 per cent. A few companies make a differential between the guaranteed rate and the rate paid as applied to options which allow withdrawal privileges and those which do not allow them. Non-withdrawal options in these cases pay higher rates of interest. For instance, the current rate being paid by one company is $3\frac{1}{2}$ per cent on dividends left to accumulate, $3\frac{1}{2}$ per cent on non-withdrawable settlement funds, 3 per cent on withdrawable, and $3\frac{1}{2}$ per cent on premiums deposited in advance.

²⁶ About 11 per cent of all death benefits in ordinary insurance and 1.5 per cent in group insurance is held at interest.

The use of a limited option as contrasted to installments for life is recommended when it is desirable to have the proceeds of a policy paid out during a relatively short period of years to cover a particular need, and when the proceeds, if paid under a lifetime-installment option, would be insufficient in amount. For instance, few would argue that it might be desirable to provide a widow with an income of \$300 a month for life. If, however, a \$20,000 policy will provide her, say, with a lifetime income of only about \$65 a month, it might be better to pay the proceeds out under the limited-installment option. In this way the insurance will provide an income sufficient to permit her to maintain her family and educate her children, even though that income terminates before her death. The children may be in a position to take care of themselves and their mother, too, when the fixed period expires.

Specifically, a widow aged 35 will receive about \$65 a month guaranteed from \$20,000 on a life-income option. Under the limited-installment option at 2½ per cent, she will receive a guarantee of about \$188 per month for ten years. If there is Social Security to supplement the \$188, it may be adequate to support the children until they reach maturity. It is generally considered sound insurance planning to spread the insurance income thick enough to cover minimum living expenses over a short period of time rather than to spread it too thin over a long period of time to be of any real help. Table 17 shows the amounts of monthly income per \$1,000 of proceeds which limited-installment options will pay for different numbers of years at various interest assumptions.

TABLE 17.

**Guaranteed Installments of Principal and Interest per \$1,000
of Proceeds**

<i>No. of Years Payable</i>	<i>Monthly 2%</i>	<i>Monthly 2½%</i>	<i>Monthly 3%</i>
5	\$17.49	\$17.70	\$17.91
10	9.18	9.39	9.61
15	6.42	6.64	6.87
20	5.04	5.27	5.51
25	4.22	4.46	4.71
30	3.68	3.93	4.18

The time option was first used by company practice in 1867. About 1889, companies began including the option by rider. Soon thereafter, companies began to include the option in the body of the policy. Today these options are almost universally granted.

Installments in Fixed Amounts. The installments-in-fixed-amounts option—often called the “amount option”—provides for payment of an unvarying annual, semi-annual, quarterly, or monthly installment of a predetermined amount until the proceeds and the interest thereon are exhausted. The desired

size of each installment determines the length of the income period, in contrast to the fixed-period option, where the length of the period selected determines the amount of the income.

Since the fixed-amount option provides for installments in definite sums, any excess earnings apportioned on the unpaid principal will lengthen the income period rather than increase the size of the payment. Any fractional amount of the proceeds and interest remaining at the end of the income period will be paid with the last full installment.

The advantage of this option is that the income is exactly the same each month until all the proceeds with interest are exhausted. The beneficiary can budget with more assurance and exactness. Of course, unless adequate provision is made for continuing the desired income for a long enough period, there is danger that the proceeds may be exhausted just at a time when continuation of the income is essential. Again, as in the case of the limited-installments option, it is frequently better to be certain that the beneficiary will have a specified and adequate income for a limited period than a smaller income for life.

Table 18 illustrates the guaranteed length of time for which a given monthly income will be provided by various amounts of proceeds at 2 per cent under this option.²⁷

TABLE 18.

**Length of Time Various Incomes Are Provided by Various
Amounts of Proceeds—2½ % (Amount Option)**

<i>Monthly Income Desired</i>	<i>Amounts of Proceeds</i>							
	<i>\$1,000</i>		<i>\$3,000</i>		<i>\$5,000</i>		<i>\$10,000</i>	
	<i>Years</i>	<i>Months</i>	<i>Years</i>	<i>Months</i>	<i>Years</i>	<i>Months</i>	<i>Years</i>	<i>Months</i>
\$ 50	1	8	5	3	9	3	21	5
60	1	4	4	4	7	7	16	11
70	1	2	3	8	6	5	14	0
80	1	0	3	2	5	6	12	0
90	0	11	2	10	4	10	10	6
100	0	10	2	6	4	4	9	3

One additional point should be kept in mind in deciding whether to select the amount option or the time option. Some policies mature at death with a loan outstanding against them. In such cases the time option would reduce the amount of each periodic payment, whereas the amount option would reduce the number of period payments. Also, the amount of the insurance proceeds may have been increased by dividend additions. Under the time option, these additions increase the amount of each payment, whereas the amount option will increase the number of periodic payments.

The fixed-amount option is one of the newer options, making its first

²⁷ Occasionally, a company will guarantee higher interest rates under fixed-period and fixed-amount options than it will under the interest-only option.

appearance in 1901. It did not become rather generally used until the twenties and thirties.²⁸

Life Income. Under the life-income option, the proceeds of the policy are retained by the company and paid in equal annual, semi-annual, quarterly, or monthly installments for as long as the payee lives. Often the option guarantees payments for a minimum number of years, usually ten or twenty. At the death of the payee, the present value²⁹ of any unpaid guaranteed installments will be paid in one sum to the executors or administrators of the payee, or payments will be continued to, or commuted for, any named contingent beneficiary. There are, then, two life-income options: those payable for life only, and those payable for a fixed number of years (or guaranteeing a fixed minimum amount of dollar payments) and life thereafter. This latter variation will be recognized at once as a type of refund annuity.

The life-income options bring to the payee advantages of the annuity discussed in Chapter 5. If the periodic income available under the life-income option is sufficient, then it is the most valuable of all settlement options, for it provides the insured or his beneficiary a given income for life³⁰

Table 19 gives the guaranteed monthly incomes payable for \$1,000 of face amount under the life-income option for life only and for ten and twenty years certain, using a 2 per cent interest assumption.³¹

The problem involved in choosing between various certain periods and life-only options are no different from those discussed in the chapter on annuities. Where the beneficiary has dependents, or has not yet reached retirement age, it is wise to select a period certain. The length of the period to be selected depends upon the length of the period of the dependency involved. A glance at Table 19 will reveal that a life-only option does not become attractive for a woman until beyond age 60; a period-certain feature also might prove profitable for an entirely different reason. A practice of some companies is to

²⁸ About 7 per cent of all death benefits paid under both ordinary and group policies are paid under limited-period options (fixed period and fixed amounts)

²⁹ Usually commuted on the basis of 2 per cent to 2½ per cent compound interest per annum.

³⁰ Do not be confused by the term "the insured or his beneficiary." The option is used by the insured to provide himself with a retirement income with the cash values of a whole life policy or the proceeds of an endowment. The option is used by the beneficiary (whether selected by the insured or beneficiary) to provide her with a life-time survival income upon death of the insured.

³¹ Many companies now guarantee 2½ per cent. To show the difference that can be made by an additional 0.5 per cent the following schedule of payments at 2½ per cent are presented along with the 2 per cent schedule.

Life Only					
Age	Female		Age	Female	
	2½%	2%		2½%	2%
25	\$2.91	2.64	50	\$4.08	3.87
30	3.05	2.79	55	4.51	4.33
35	3.23	2.98	60	5.07	4.91
40	3.45	3.22	65	5.80	5.68
45	3.73	3.51	70	6.75	6.68

TABLE 19.

**Monthly Income per \$1,000 at Various Ages Under a Life-
Income Option ***

Male	Age ^a Female	Life Only	10 Years Certain and Life	20 Years Certain and Life
	20	\$2 51	\$2 50	\$2.49
20		2 64	2 63	2 62
	30	2 79	2.78	2 76
30		2 98	2 97	2 93
	40	3.22	3 20	3 13
40		3 51	3 47	3 37
	50	3 87	3 81	3 63
50		4.33	4 23	3 92
	60	4 91	4.73	4 22
60		5 68	5 34	4 50
	70	6 68	6 04	4 74
70		8 02	6.82	4 91

^{*} 1937 Standard Annuity Table, 2%, rated down one year.

^a Male takes female rate five years older.

pay dividends for excess interest earned during the guaranteed period but disperse with participation after the guaranteed period expires. Thus, if dividends are paid, the actual periodic payments received during the guaranteed period might be greater than those under the life-only option, especially at younger ages.³²

Joint and Survivorship. Some contracts include as an option the privilege of having the cash values or proceeds distributed as an income payable until the death of the last survivor of two persons. The option may or may not offer a minimum number of guaranteed payments, and most often is selected when the cash value of a policy or the maturity proceeds of an endowment are taken as a retirement income for a husband and wife. The joint-and-survivorship option guarantees income to a man and his wife as long as either shall live, whereas the use of the regular life-income option would provide a retirement income only as long as the policyholder himself lives or for the guaranteed period, if that be longer. The joint-and-last-survivor option also is used when it is desirable to provide a lifetime income for two beneficiaries, a mother and a father, for example. The amount of each payment under the option is based on the ages of both beneficiaries. Some options provide for a decrease in the income upon the first death to about $\frac{2}{3}$ of the joint income.

Table 20 shows the monthly installments per \$1,000 of proceeds payable under the joint-and-last-survivorship option in a given company.

The option was first issued in 1901 as a special agreement. Now many companies will include the option by rider and some include it in the contract.

³² Some companies allow no participating dividends under any type of life-income option, whereas others allow participation under all life-income options for the full life of the option.

TABLE 20.

**Special Joint and Survivor Settlement Monthly Installments
per \$1,000 of Proceeds**

<i>Male Age</i>	<i>Female Age</i>	<i>Life Annuity as Long as Either Lives Joint and Survivor Income</i>	<i>Life Annuity Reduced to $\frac{2}{3}$ at First Death Joint Income</i>	<i>Income to Survivor</i>
60	56	4 12	4 75	3 17
60	57	4 17	4 81	3 21
60	58	4 23	4 87	3 25
60	59	4 29	4 94	3 29
60	60	4 34	5 00	3 33
60	61	4 40	5.07	3 38
60	62	4.46	5 14	3 43
65	61	4 60	5 38	3 59
65	62	4 67	5 46	3 64
65	63	4 75	5.54	3 69
65	64	4 82	5 63	3 75
65	65	4 90	5 72	3 81
65	66	4 97	5 80	3 87
65	67	5 05	5 89	3 93

Other Options. Most life insurance companies will, in addition to the optional modes of settlement offered in the contract, permit the election by the policyholder in advance of his death, or by the beneficiary thereafter, of any reasonable and sound mode of settlement. Many companies, further, will write special settlement agreements which they will attach to and make a part of the policy contract.³³ For example, some companies will write a remarriage clause in the option agreement under which the funds will be paid to the primary beneficiary (in this case the widow) as long as she does not remarry. Upon proof of her remarriage, the funds go to the secondary beneficiary. Notification and burden of proof of remarriage usually are on the contingent beneficiary or guardian.³⁴ A number of companies include a clause which makes payments for education contingent upon submission of a certificate of attendance at a college or university.

³³ At the present time it is the practice of some companies to provide in special settlement agreements that the options selected under them shall be the options, not in the policy, but those in use by the company at the time the option goes into effect. A number of observers question the ethics of this provision on the grounds that (1) it denies the policy the certainty which is one of the values of life insurance and (2) breaches the contract in effect if not in law. The authors have, on occasion, discussed this practice with company legal counsel and found that in at least some instances, counsel of companies following the practice doubt not only the ethics of it but also the legality. Remarked one counsel: "This is a practice forced on me by the actuarial department on the basis of so-called 'actuarial principles', but I have never been able to get them to give me dollars and cents figures on the potential loss involved in standing by the options in the policy, and I dread the day I may be called upon to defend the provision in suit."

³⁴ Often the guardian and the primary beneficiary are the same, so that such a clause might be ineffective. It is questionable, however, whether or not a remarriage clause is in the best interest of society.

Advantages of Settlement Options. Among the most important provisions of the life insurance contract are those dealing with settlement options. It is through the selection of the proper options that better insurance programs are built. The use of income options rather than lump settlements has several advantages. (1) It demonstrates the importance of adequate insurance coverage by stressing the amounts of life insurance necessary to fill specific needs. (2) It enables the policyholder to leave an assured income to take care of his family rather than a principal sum to be taken care of by his family. The fund is managed by the insurance company and not exposed to the hazards of investment by inexperienced hands. (3) It applies the annuity principle of liquidation and thus provides the largest possible return commensurate with the degree of safety afforded. (4) It enables the assured to take advantage of certain quasi-trust services of life insurance companies. (5) It offers certain tax advantages which are explained in Chapter 17. (6) It makes possible the use of spendthrift trust clauses as described in Chapter 8. (7) It enables the policyholder to take advantage of the common-disaster clause as described in Chapter 9. (8) It assures that the policy proceeds will earn interest immediately upon the insured's death until needed.

Limitations of Settlement Options. Three limitations present themselves in planning income through the use of settlement options. (1) The guarantees are generally so conservative that if the program is based on them, more participating insurance than will probably prove necessary will be needed to provide the desired income. Companies frequently pay more than the guaranteed rate so that the desired program can usually be achieved with less insurance than is proposed. The big question here is whether to plan on the basis of the low guarantees or on what the companies are likely to pay. (2) Any long-range financial plan based on a fixed dollar income is exposed to the purchasing power risk. In this age of inflation, this can be a serious matter. The use of settlement options may foster too heavy a reliance on fixed dollar incomes. (3) The use of settlement options may put the beneficiary in a strait-jacket by tying the program too tightly. It is important not to overlook the need for flexibility in selecting settlement options. More will be said on this subject in Chapter 16.

The actual use of settlement options in life insurance programming is discussed in Chapters 15 and 16.

4. SUMMARY.

Life insurance policies contain three groups of options which are open to the policyholder (and in some cases to the beneficiary): nonforfeiture options, dividend options, and settlement options.

The nonforfeiture options are cash, paid-up insurance of reduced amounts, and extended term insurance. Dividend options include cash or offset against premium, paid-up additions, accumulation at interest, accelerative endowments, and sometimes one-year term. Settlement options include interest only, fixed

period, fixed amounts, life income, and joint and last survivorship. If no settlement option is selected, the policy proceeds are usually paid in cash

In order to get the most from his insurance, it is imperative that the insured study all his options and make the best possible selections in keeping with his objectives.

QUESTIONS FOR CLASS DISCUSSION

1. Your uncle has a \$20,000 continuous-premium whole life policy which has been in force for thirty years. He no longer wants to pay the premiums on the policy. What information would you need in order to be able to advise him in his choice of options?
2. When there is indebtedness outstanding and a policy is put on the extended term, nonforfeiture option, how do you explain the logic behind subtracting the debt from both the face value and the cash value of the policy?
3. Your roommate tells you he is going to purchase a \$25,000 continuous-premium whole life policy and surrender it for its cash value in about thirty years. Would you say he is buying the wrong policy since he does not plan to hold it to maturity?
4. Assume that a friend of yours buys a \$30,000 continuous-premium whole life policy at age 35. How much monthly income will it pay him at age 65 if he takes part of the nonforfeiture value as a paid-up policy for \$5,000 and the rest as a retirement income?
5. Describe the circumstances under which you would recommend the selection of each of the following dividend options: (a) cash, (b) paid-up additions, (c) accumulation-at-interest, (d) the accelerative option, and (e) the one-year term option.
6. Explain why a policy will mature earlier under the accelerative endowment plan than is possible under the accumulation-at-interest dividend option.
7. What factors should be taken into consideration in making a selection between the fixed-amount and the fixed-period options?
8. Describe as many situations as you can under which you would recommend the use of the interest-only option.
9. Why do some companies guarantee higher interest rates under some options than under others? Why do some companies guarantee higher interest rates for settlement options than other companies?
10. Under what circumstances would you recommend each of the following methods of settlement of a life insurance contract? (a) Life income twenty years certain, (b) life income no years certain, (c) joint-and-last-survivorship income, and (d) lump sum payment.

CHAPTER 11

Health Insurance¹

Life insurance pays the cost of dying and offsets the loss of earning power brought about by death. It can also be used to arrange an income for old age. Other perils giving rise to loss of income and expenses are accident and sickness. In fact, statistically, accident and sickness are more frequent than death. Death and old age occur once in a lifetime. Accident or sickness may strike several times. "The probability of a long-term disability . . . is at least equal to the probability of death on an age-specific basis," states O. D. Dickerson.²

Since life and health insurance both deal with the same economic factor—expenses arising from a fortuitous event and loss of earning power—and since life insurance companies write over 80 per cent of the health insurance premium volume in the United States, a study of life insurance is not complete without an understanding of health insurance.

1. THE NEED FOR HEALTH INSURANCE.

Injury and sickness can bring about two kinds of financial loss: (1) loss of income resulting from inability to work, and (2) expenses of medical, hospital, and nursing care, including all the incidentals such as the "wonder drugs."

Of every 1,000 working persons in the United States 17 years of age and older, 104 lose some time from work during a typical year because of accidental injury.³ Nearly 22,000,000 people—one out of eight—are admitted to hospitals in such a year. On an average day, 451,000 (2.6 per 1,000 population) are hospital-confined. An average of 59,000 enter hospitals each day. Seven out of ten of those hospitalized remain in the hospital 8.6 days, and 60.1 per cent are treated surgically.

¹ "Insurance against loss by sickness or accidental bodily injury (Sometimes called 'Accident & Sickness' or 'Accident & Health' insurance and sometimes also used to mean insurance covering only sickness or medical expense.)" Definition adopted by the Committee on Health Insurance Terminology of the Commission on Insurance Terminology of the American Association of University Teachers of Insurance.

² O. D. Dickerson, *Health Insurance* (Richard D. Irwin Co., Homewood, Ill., 1959), p. 6.

³ Statistics on the incidence of accident, sickness, hospitalization, and medical care and the costs and dollar losses incurred are from the *Source Book of Health Insurance Data* (New York 22, N.Y., Health Insurance Institute, annual) unless otherwise noted.

The average person in the United States makes five visits a year to a physician. Annually, over three-quarters of a million persons are disabled by sickness for three months or more, and close to half a million are disabled for six months or more.⁴ It has been said that the greater incidence of disability over death is dramatized by the fact that the classified section of the telephone book in a typical city contains six to eight times as many listings of physicians as it does of undertakers—and so many things can go wrong with the human body that it takes a 1,600 to 2,000-page medical dictionary to define them.⁵

2. TYPES OF COVERAGE AVAILABLE.

Although health insurance coverages vary widely, they may be broken down for practical discussion into a relatively few broad, basic types.

Accident Coverages. Insurance against loss from accident is the “grandfather” of all health insurance coverages. Accident insurance⁶ is still widely sold under separate policies and as a part of contracts covering both accident and sickness. Benefits may be limited to lump sums or may include a series of periodic payments to offset loss of earned income.⁷ In general, accident insurance policies provide for valued payments⁸ for accidental death⁹ and dismemberment. When the policy does not include loss of time (income) benefits, valued benefits are also usually available for certain fractures and dislocations. When loss of time benefits are written, valued benefits for fractures and dislocations may be optional; i.e., the insured may, at the time of the injury, select these valued benefits in lieu of the loss of time benefits. Occasionally, the policy may provide for the payment of the valued benefit for the fracture or dislocation plus loss of time benefits.

In addition to these valued benefits and a weekly or monthly income for loss of time, accident policies may also offer certain expense benefits. These may provide for the actual cost of hospitalization, medical, nursing, and surgi-

⁴ *A & H Bulletins*, “Sales Section” (Cincinnati, the National Underwriter Co., monthly).

⁵ R. W. Osler, *Guide to Accident & Sickness Insurance* (Indianapolis, 1959, the Rough Notes Co.), p. 12.

⁶ Defined by the Committee on Health Insurance Terminology as “a subdivision of health insurance against loss by accidental bodily injury.”

⁷ Loss that is either real or presumptive. For instance, a policy may pay a weekly or monthly benefit during a period of time during which the insured is unable by reason of accidental bodily injury to perform any of the duties of his own occupation. During that time, he might be able to work at some other occupation and, in fact, might do so and earn income therefrom while still receiving the benefits from the policy. In other words, it is presumed that inability to perform the duties of his own occupation will mean loss of income, if it does not, the benefit is nevertheless paid.

⁸ That is, stated, fixed amounts. Thus the valued benefit for loss of sight of both eyes may be \$1,000.

⁹ Accidental death is not a health insurance coverage but a life insurance coverage used in a health insurance policy—just as many life insurance policies use such health insurance coverages as waiver of premium in event of disability and as income benefits in case of disability.

cal care up to a given maximum written on a blanket basis;¹⁰ or they may be paid on a fixed basis; i.e., a flat amount payable without regard to the actual cost incurred during hospital confinement or the use of private-duty nursing care.

Certain "frill" benefits may also be offered; for example, multiple benefits (double, triple, or even more) for certain uncommon causes of injury such as hurricanes, tornados, lightning, or explosions of steam boilers. Multiple benefits may extend to the insured who is injured in a common carrier or while a passenger on a passenger elevator.¹¹

Sickness Coverages. Sickness insurance¹² developed more slowly than accident, largely because of the lack of reliable statistics and because of the greater moral hazard involved.¹³ Sickness coverage is rarely sold separately from accident.

With the exception of death, dismemberment, loss of sight, and dislocation and fracture benefits, the types of benefits available under sickness coverages are the same as those offered under accident coverages.¹⁴ Basic medical benefits under sickness insurance usually are written scheduled rather than blanket.

Hospital Coverage. Policies are also offered that cover the cost of hospitalization only and, to a varying degree, the charges incidental to such hospitalization.¹⁵ This type of coverage is the "baby" in health insurance in date of origin but is the most extensive in number of persons covered¹⁶ and in volume of premiums written. The coverage is written on an individual basis, family basis, or group insurance basis—the last also often including dependents of the covered member of the group.

¹⁰ That is, lumping all covered costs together rather than setting up a schedule of maxima that will be paid for each type of expense.

¹¹ Multiple benefits for uncommon accidents lend themselves to dramatic sales presentations with little or no addition to the premium. In an economic sense, they are difficult to justify. Why does a man need larger benefits because his disability is from the explosion of a steam boiler than he does if he is disabled by a fall down steps? These "frill" benefits are gradually dropping into disuse.

¹² Defined by the Committee on Health Insurance Terminology as "a subdivision of health insurance against loss by sickness," which may include mental illness, pregnancy, and certain forms of preventative and diagnostic medicine.

¹³ This means, bluntly, that it is easier to fake disability from sickness than it is to fake disability from accident.

¹⁴ Sickness insurance never covers death, death by sickness being deemed "natural" death and covered only by life insurance. Also, sickness does not produce dislocations, fractures, etc.

¹⁵ "Miscellaneous" or "ancillary" charges such as operating room, anesthesia, drugs, dressings, etc.

¹⁶ Approximately 125,000,000 persons have hospital expense coverage. Fifty-four per cent are covered by regular insurance companies, 42 per cent by the various Blue Cross-Shield and medical-society-approved plans, and 4 per cent by independent plans. In contrast, approximately 115,000,000 persons have surgical expense coverage; slightly over 75,000,000, regular medical expense; almost 20,000,000, major medical coverage; and fewer than 50,000,000, loss of time. Exact figures for any given year are available from the *Source Book of Health Insurance Data* cited in footnote No. 3.

Hospitalization policies cover two basic items: daily charges for hospital board and room (and the floor nursing and routine services included in that charge) and the charges for miscellaneous (or "ancillary") hospital expenses such as operating room, laboratory, and similar costs as previously mentioned.

Also available are hospital policies that provide a flat amount per day of hospitalization regardless of actual expenses incurred.¹⁷ Thus the policy will pay, say, \$20 a day if the insured is necessarily confined to a hospital for a maximum of sixty days, ninety days, six months, or a similar period. The benefit may be stated in terms of monthly payments. The policy form may include dependents, although the per diem for dependents may be less than that for the insured. The same coverage is often offered as a rider on a disability income policy or even on a major medical policy with the maximum benefit limited to the amount of the deductible under the major medical policy.

A third type of hospitalization coverage offered is the "service-incurred" plan, most widely seen in the various Blue Cross contracts. In this type of coverage the basic benefit is not cash but payment of covered expenses when the insured¹⁸ is confined in a hospital participating in the particular "plan." Cash benefits are usually paid only when the insured is confined in a hospital not participating in the Blue plan under which he is covered.

Surgical Expense Coverage. The basic form of surgical expense coverage is a schedule of specified maxima that will be paid for various listed operations, which list includes most surgical procedures known. Allowance for procedures not listed usually is made by a provision that the benefit will be that of the most nearly related procedure.

In the schedule, the most expensive types of surgical procedures carry the maximum benefit with all others scaled down proportionately. A typical schedule will list thirty-five or more procedures ranging from a maximum benefit of \$200 for cutting into the cranial cavity or removal of a lung or portion of the vertebrae down to, perhaps, \$10 for suturing a wound. The coverage provides that the "regular and customary charges" will be paid for any operation up to the listed maximum. The schedule is referred to in terms of its maximum benefit. Thus, a schedule that pays up to \$300 for some several procedures is called a "\$300 schedule."

Surgical schedules vary not only in maximum amounts for major operations but also in the proportion of this maximum that is allotted to lesser procedures.

¹⁷ This type of policy is often called an "indemnity" policy (in an attempt to make a distinction from the "reimbursement" type policy). The term "indemnity" is completely inappropriate. A possible substitute name, but one having no standing in common usage as of now, is a "valued" hospitalization policy, or "valued benefit" policy.

¹⁸ Most Blue plan carriers will contend that they are not insurers and that the coverage they offer is not insurance. This contention is often successful in winning tax advantages for them in various jurisdictions and succeeds in keeping them out from under full insurance department regulation in nearly all jurisdictions. Only in Indiana are the Blue plans (Cross and Shield) issued by companies organized under the laws for domestic mutual companies.

Surgical schedules may be an integral part of a hospitalization policy, they may be attached by rider, or they may be attached to an accident policy or a loss-of-time policy by rider.

Medical Expense Coverage. Medical expense coverage is written to cover physicians' bills other than surgery. It is of several types: it may be written to pay, irrespective of disability; it may be limited to expenses while a policyholder is disabled as defined in the policy; or it may be limited to payment of such expenses only while the insured is hospitalized.

Any one of three limitations, or a combination of them, is common in medical expense coverage: (1) exclusion of the first few calls by the physician; (2) a limit on the amount per call or per day; (3) an aggregate amount that will be paid for medical attendance. Benefits for house calls are usually higher than those offered for office calls. Benefits may be added to most medical expense plans to pay the costs of scheduled diagnostic procedures, or such procedures may have blanket coverage but be limited in aggregate amount.

As mentioned, an accident policy often includes blanket expense coverage under which all medical costs (hospital, surgical, physician, etc.) will be reimbursed on a non-scheduled basis up to an aggregate amount per claim. Blanket expense coverage is available through limited policies that cover expenses for certain diseases only, such as poliomyelitis, scarlet fever, meningitis, tetanus, diphtheria, cancer, and sometimes others. In such policies the maximum that will be paid over-all is usually high: \$5,000 to \$10,000 or even more in some policies.

Medical expenses may also be provided for through a medical or nurse rider on a disability income policy. Such a rider pays a flat amount per day for a stated number of days (or months) if the insured requires regular medical care or the services of a registered nurse.

Medical expense coverage is also available through the Blue Shield plans on a semi-service-incurred basis; i.e., participating physicians agree that in the case of persons covered by the plan whose incomes are below a certain level (varying from community to community), the amount paid directly to the doctor by the Blue Shield plan is full payment. However, in the case of covered persons with an income above the agreed maximum, the payment made by Blue Shield is only partial payment, the physician being free to charge as much more as he wishes.¹⁹

¹⁹ Historically, the medical profession has always charged according to its presumptions of the ability of the patient to pay. Thus, any two patients may pay entirely different amounts for exactly the same treatment. As a body, the profession pursues this principle down to the lowest level: the patient with no ability to pay is not charged—or at least no real effort is made to collect any bill sent him. To an extent, hospitals also charge on presumed ability to pay. Patients in private rooms will be charged not only a higher daily board and room rate but also more for medications, treatments, etc. For this reason, Blue Cross plans pay on a service-incurred basis only for semiprivate facilities. If a Blue patient wishes private facilities, the plan makes an allowance on the charges rather than paying for all services incurred (When the statement is made that Blue Cross pays for "services incurred," it should be held in mind that it pays for such services *only* if they are covered in the contract. The Blue plans have exclusions and limitations just as do other insurance policies.)

Major Medical Coverage.²⁰ Major medical is the newest of all forms of medical expense coverage (using "medical expense" broadly to include not only physicians' and surgeons' bills but also hospital board and room, ancillary charges, nursing care, prosthetic devices, etc.). The policy, written on an individual, family, or group basis, provides virtually blanket protection for medical expenses up to a given maximum. The coverage also uses a "deductible"; i.e., the first \$250, \$500, \$750, or \$1,000 of expenses are not paid, thus eliminating the cost of small claims in the interest of paying those more likely to be economically disastrous. The deductible (as in the case of automobile collision insurance) permits the writing of high maxima of coverage at a premium that is moderate in comparison to plans covering the first dollar of expenses but paying less than the maximum offered by major medical.

Usually the maximum benefit applies to each accident or each sickness. A new accident or sickness, or even a recurrence of a previous one if separated from the treatment for it by some such period as six months, will be treated as a new "case" for which the maximum is again available. In some cases, especially in coverage extending beyond the ages of 60, 65, or 70, the maximum may be aggregate: When covered expenses for any and all accidents or sicknesses have totaled the maximum, the policy expires.

In widespread use in major medical policies (and even sometimes in basic hospitalization policies for certain coverages such as ancillary charges) is what is confusingly termed a "co-insurance" clause.²¹ The clause provides that after the deductible has been accumulated, the policy will pay 75 per cent or 80 per cent of the charges incurred up to the maximum. The underwriting theory involved is that if the insured is paying part of the cost, he will have a greater incentive to recover—and less incentive to use unnecessary services.²²

Group major medical is usually written in conjunction with a basic (first-dollar) plan. In such cases, what is known as a "corridor deductible" may be

²⁰ When this coverage first appeared (approximately in 1950), it was frequently called "catastrophe" insurance. The term was descriptive but conflicts with the usage of the same term in the casualty insurance field and in reinsurance. A variation is "major hospital expense" under which the coverage applies only in case of hospitalization. Some major medical policies provide that expenses will be paid in or out of the hospital for some such period as a year but after that period, only if hospitalization is required.

²¹ "Confusingly" because the use here is utterly different from that in the case of fire insurance. The use of the term "participating feature" is gaining popularity.

²² Another way of handling the problem of overutilization or prolongation of medical services is to put "internal limits" in the major medical policy. A common internal limit is the amount that will be paid for hospital daily board and room. Because private-duty nursing is often overutilized when expenses are covered on a blanket basis, some policies that do not use an over-all co-insurance clause will apply co-insurance to such nursing care only. A third type of internal limit is a maximum amount per operation or series of related operations. Some major medical policies are even using a surgical schedule. All these internal limits are contrary to the principle of major medical, which is to offer as near to blanket coverage as possible, however, overutilization of medical facilities and overcharging for services where the purveyor of them knows blanket major medical is in force have so seriously threatened the continued existence of the form, that many authorities see internal limits as the only hope of saving it even though these limits are contrary to the basic principle.

applied: the deductible is whatever is paid by the basic plan plus \$100 or \$200 (or any amount, although those mentioned are common). Whenever medical bills that are not covered by the basic plan exceed the deductible, the major medical plan becomes operative. To illustrate, assume a corridor deductible of \$200 and medical bills of \$1,200, of which the basic plan pays \$900. The covered person pays the next \$200, and the major medical plan pays the final \$100. It is possible, of course, for the covered person to be receiving benefits from the basic plan and the major medical plan simultaneously. Assume, for example, that the same \$1,200 of expenses are incurred but that the disability is a continuing one. The covered person might be incurring, at one and the same time, bills still covered by the basic plan but also bills not covered by it but in excess of the corridor deductible.

Another type of major medical insurance is known as "comprehensive" major medical.²³ This is usually a plan with a very low deductible, \$25, \$50, \$100, but the high maxima of major medical. In this case the deductible is on the first dollar of expense, not on a "corridor."

Deductibles in individual major medical are usually on a "per case" basis. Thus, under a \$500 deductible, \$500 of covered expenses must be incurred for any one accident or sickness before the insurance becomes payable. In the case of group insurance the deductible is more often on an annual basis: whenever the covered person has accumulated a total of all bills for all accidents or sicknesses during a year in excess of the deductible, the insurance starts paying.²⁴

3. CONTINUATION PROVISIONS.

Accident, sickness, and medical-expense policies may be classified by continuation provisions. Any of the coverages previously discussed can be written on any one of the following bases:

- (1) Non-cancellable, guaranteed renewable
- (2) Guaranteed renewable, adjustable premium
- (3) Restricted termination right
- (4) Optionally renewable
- (5) Cancellable
- (6) Nonrenewable

Non-cancelable, Guaranteed Renewable. Policies that cannot be canceled by the company, that can be renewed by the timely payment of premiums until a stated age or for a stated number of years,²⁵ that cannot be

²³ Terminology in major medical is even less well organized than in the other areas of health insurance. Not everyone will use the term "comprehensive" to designate the type of coverage described here.

²⁴ The authors cannot refrain from the passing remark that some "wild" things are being done in the realm of group major medical—things that could "break" the coverage.

²⁵ Technically, in the definition of non-cancellable adopted by the National Association of Insurance Commissioners in 1959, the policy must be so renewable until at least age 50 or, if issued after age 44, for at least five years. Most such policies guarantee renewal until 65. Age 60 is sometimes used, and age 70 is beginning to appear.

changed by the company by rider while in force, and on which the premium in effect at time of issue is guaranteed for the life of the policy are called "non-cancellable, guaranteed renewable." In trade argot, this is usually shortened to "non-can." In an attempt to make the nature of the continuation clause even clearer to the public, "and guaranteed premium" is sometimes added. For the sake of space, policies containing this type of continuation provision shall be referred to here as "non-can."

The widest application of non-can is in the field of loss-of-time insurance. It can be found in medical expense coverages, but has not developed widely there because of the steady increase in medical care costs. It is next to impossible to set a premium for thirty-five or forty years into the future when there is no way to determine what the losses will be so many years hence.

Commonly, applicants for non-can above age 45, say, and with more than \$200 a month in force or applied for are medically examined. Rates for similar benefits are usually higher than in other forms.²⁶

Guaranteed Renewable, Adjustable Premium. Guaranteed renewable, adjustable premium is a new form of continuation provision, developed largely because of the problems in applying the non-cancellable, guaranteed renewable, fixed-premium continuation provision to medical care forms. Policies using the guaranteed renewable, adjustable-premium, continuation provision may be renewed by the timely payment of premiums to the same given ages or for the same number of years as non-can; the company cannot alter the benefits while the policy is in force; *but* renewal is at the rate in effect for all policies of the same class on the date of renewal. "Class" may mean such things as "all policies bearing this form number," "classified by age and sex," "classified according to age of entry," or others. In other words, the company cannot change the premium for any one individual unless it changes it for a whole group of individuals classified in the same way.

The guaranteed renewable, adjustable-premium policy cannot be canceled, either; but "non-cancelable" "is not used to describe it since that term is confined to the form under which premiums also are guaranteed.

Guaranteed renewable (to use the short form; in trade argot it is sometimes referred to as "GR") makes it possible to give the policyholder assurance that his coverage will continue in force while not requiring the company to make impossible guesses as to future limits of loss. Thus, while the only way the non-can provision can be applied to major medical, for instance, is by setting a premium that is much higher for today than it needs to be in order to meet estimated increases in the cost of medical care years in the future, guaranteed

²⁶ Non-can advocates will be thoroughly dissatisfied with this brief treatment of the subject. They contend that non-can is a class of health insurance all by itself. However, any system of classification that sets up non-can as a class of policy runs into inconsistencies. The authors know, because in past editions they have tried different classification systems in an attempt to do it! The discussion here follows the pattern of a classification system developed by the Committee on Health Insurance Terminology just seven days before this writing. It classifies health insurance as to perils covered, contractual arrangements, types of losses, bases of payment, types of benefits, continuation provisions, and methods of merchandising.

renewability can be achieved on the GR basis at rates known to be adequate for today without trying to estimate (and even perhaps overestimate) what they will have to be twenty-five years from now.

Guaranteed renewability is also being applied to disability income forms. It gives the insured the guarantee of continuation of coverage without requiring a premium quite as high as non-can.²⁷

Guaranteed renewability also makes possible the use of higher age limits. Companies are beginning to write medical care policies, for instance, that are renewable for life. In addition to the fact that no one can predict where medical care costs are going and cannot, therefore, estimate future benefit-payment loads, no one knows what the possession of medical care insurance by a large segment of the elderly population will do to the utilization of facilities—except to be very sure that it will increase the use.²⁸ Policies renewable at the option of the company and cancellable provisions provide the safeguards needed against spiraling medical care costs, but the public does not like health insurance coverage that can be canceled or that might not be renewed. The adjustable premium provision makes it possible to guarantee renewability while, at the same time, permitting the company to increase rates if such an increase is necessary in view of the loss ratio.

GR should also make possible loss-of-time policies that are guaranteed renewable as long as the insured is employed full time.²⁹ Non-can and GR provisions can be combined. The policy can be non-cancellable to age 65 and guaranteed renewable thereafter.

Restricted Termination Right.³⁰ Some continuation clauses provide that renewal is at the option of the company but that the company will not refuse to renew solely on grounds of deterioration of health. Under an optionally renewable or cancellable continuation provision, coverage for an insured who has suffered a heart attack may be³¹ terminated—or renewed only with a waiver of liability in event of any further cardiovascular-renal condition. Under a restricted termination right clause, the policy could not be terminated

²⁷ However, GR rates as high as some non-can rates can be found; conversely, GR rates as low as some optionally renewable rates also exist.

²⁸ At any age, the incidence of hospitalization among those having hospital insurance is greater than among those not having it. It is this factor that makes cost estimates for any government-subsidized system of hospital "insurance" for the aged little more than guesses.

²⁹ If the insured is not employed, then disability does not cause loss of business time or earned income, and the coverage becomes unnecessary or inapplicable.

³⁰ This terminology is not yet standard but has been tentatively agreed upon by the Committee on Health Insurance Terminology. Another proposed designation for this provision is "limited renewal right."

³¹ "May be" because many companies writing optionally renewable and cancellable coverages rarely if ever terminate for deterioration of health alone. One company that had written only optionally renewal policies throughout its history until 1960 told the authors that a survey of its claim records showed that in ten years it had never terminated a policy for deterioration of health alone. In other words, it was handling its policies as though they included the restricted termination right clause although not getting the sales advantage of having such a clause in its policies. It has now shifted completely to a GR basis.

for this cause alone. Such a clause, in effect, restricts termination to cases of poor moral risk, evidence of excessive claims, development of bad habits, and the like. Under some continuation clauses, the insurer cannot deny renewal unless it denies renewal on all policies of the same class.

Optionally Renewable Policies. Policies containing this continuation provision are renewable at the option of the company only. Further, at any renewal date, the premium may be changed or a restrictive rider added. In effect, the company can say one of three things: "We will not renew this policy." "We will renew this policy only for \$X of additional premium." "We will renew this policy only if coverage or benefits are restricted by the following rider."

Cancelable Policies. This continuation provision permits the company to cancel the policy at any time on due notice to the insured as provided in the policy. Whereas under the optionally renewable provision, it cannot terminate the policy until the renewal date (generally speaking, the next premium-due date), with a cancelable provision it can terminate at any time. Nearly always a policy with a cancelable clause also contains an optionally renewable clause.

The right of the company to cancel or deny renewal has been a subject of wide criticism by the public, legislators, legislative investigating committees, and even insurance commissioners. Yet two facts exist: (1) Virtually all property insurance coverages are cancelable or nonrenewable—or both—and there is little if any criticism of that fact. The insured's fire insurance, household insurance, liability insurance—all can be canceled or non-renewed. (2) Cancelable and optionally renewable provisions (a) cut premium rates to a level that put some health coverages in reach of people who otherwise could not buy; (b) make it possible for persons who could not qualify physically or by reason of hazardous occupation to have health insurance coverage; and (c) make it possible for companies to experiment with new forms of coverage on which statistical data are too limited to make non-can or even GR safe. If all optionally renewable and cancelable coverages were forced off the market (as some legislators would have it), there would be a gap in the health insurance field.³²

Nonrenewable Policies. Some few policy forms carry no renewal provision at all. The best example is trip-travel (or "ticket") insurance. The travel accident policy purchased at the airport, for example, is for the "term" of one trip. It cannot be renewed. For the next trip, a new policy must be purchased.

Group Renewability. The above discussion of continuation provisions (renewability) applies to individual (and family) policies. It does not apply to group coverages. Continuation provisions under group contracts may be classified as follows:

(1) Provisions affecting the continuance of the master contract (or segment thereof)

³² This is particularly true in the area of programming of health insurance.

- (a) Guaranteed renewable
- (b) Limited renewal right (this being applicable under a contributory plan where the policy may be terminated if less than a certain percentage of those eligible remain covered)
- (c) Optionally renewable
 - (2) Additional provisions affecting continuance of coverage of the individual
 - (a) Subject to continuance of employment (or membership in an insured group)
 - (b) Cancellable as to a class within a group.

4. CLASSES OF HEALTH INSURANCE.

In the past it has been customary to discuss health insurance policy forms in terms of "classes." Any such classification system runs into two difficulties: (1) it is impossible to find a common denominator;³³ (2) in the past decade particularly, some of the previously recognized classes have become virtually identical except for continuation provisions. For example, some companies now writing what used to be called "commercial," "non-cancelable," and "guaranteed renewable" actually use identical policy provisions save for the continuation clause.

Because the "class" terms are still in widespread use (however confused the basis of their classification) and because there are some special types of policies not easily brought into the discussion otherwise, the class terminology will be explained briefly here.

Industrial. "Industrial" policies are those issued to workers engaged in the more hazardous occupations. They may be written on a weekly premium basis with premiums collected at the door of the home or sometimes at the place of work. Usually they are issued for small benefits and for very limited income benefit durations. Like industrial life insurance, they are intended to make the purchase and payment of premiums for the coverage easier for the small buyer. Usually, also, they are cancellable and renewable at the option of the company.

Commercial. "Commercial" was originally intended to designate a type of policy more suitable for the workers in "commerce" ("white-collar workers") as contrasted to those in industry. The term³⁴ later came to be applied to policies that are cancellable, optionally renewable, or both, and written for people in the less hazardous occupations. These policies offer larger benefits for longer durations than those available under industrial forms and formerly under non-can. In fact, it is only within recent years that sickness benefits lasting until age 65 could be found in other than "commercial" policies.

³³ At least the authors have never seen a classification system that could, including those they have previously used in this text itself. Some of the "classes" will be based on methods of merchandising (industrial, for an example); others in the same list will be on the basis of continuation provision (non-can, guaranteed renewable, optionally renewable, commercial, etc.); still others will be based on the type of insurer (fraternal).

³⁴ The industry as a whole would like to get away from the word. It means nothing to the public except perhaps to carry the connotation of "profit"

Guaranteed Renewable. As previously explained, this is a relatively new form, renewable at the option of the insured only but reserving to the company the right to increase premiums by classes. In policy provisions other than renewability, GR is often indistinguishable from commercial and non-can. Often it may be guaranteed renewable beyond 65 as long as the insured is employed full-time or may become optionally renewable after 65.

Non-can. In addition to its different continuation and premium guarantee provisions, non-can, loss-of-time coverage used to be distinguishable by its more conservative benefit maxima and by its fewer "frill" benefits. Today, however, higher benefits are becoming available in policies carrying the non-cancelable continuation provision, and commercial has eliminated many of the "frill" benefits it once carried.³⁵

Group (Including Franchise or Wholesale). Group insurance forms are discussed in Chapter 13, which covers both life and health group insurance.

Limited. Limited policies are those covering only specifically named accidents or diseases. Examples are the "dread-disease" contract mentioned earlier and the "travel ticket," "newspaper," and automobile accident policies. "Travel ticket," once sold as a stub on a railway ticket, is now commonly sold over the ticket counter or, especially in airports, from vending machines. The coverage is limited to accidents occurring while the insured is a passenger on a common carrier and for the one trip alone. "Newspaper" policies, issued in conjunction with a newspaper subscription, are usually limited to a small list of accidents. Both types commonly contain a principal and a capital sum for death and dismemberment and a limited measure of expense reimbursement. Automobile accident policies cover accidents suffered while the insured is an occupant of a passenger automobile and, in some cases, a pedestrian.

Although sold at relatively low premium rates, limited policies are a source of public misunderstanding. The public, always hunting "bargains," is inclined to buy these policies without understanding that they do not pay for all accidents, not even for many of the more common ones. For that reason, limited policies are usually surprinted on the face in red with some such warning as, "This is a limited policy. Read its provisions carefully."

³⁵ With the exception noted in footnote 27, premium rates for non-can are highest, for guaranteed renewable, next highest, and for commercial, lowest. The following comparison of rates per \$100 of monthly benefit, male, is taken from the rate book of one company writing all three forms of renewability. The occupational classification is AAA (the best); the elimination period is thirty days for both accident and sickness, and the benefit durations are five years for accident and two years for sickness.

<i>Renewal Provision</i>	<i>Rates</i>	
	<i>Age 25</i>	<i>Age 45</i>
Non-can	\$24.20	\$46 10
Guaranteed Renewable	19.30	36 80
Commercial	14 40	14.40 *

* (The commercial rate runs by age brackets instead of by actual age. It does not increase between 16 and 51.)

Special Risk (or "Specialty"). Special risk coverage offers the customary benefits or any combination of them found in orthodox health insurance policies but usually features higher limits and underwrites hazards not written in orthodox policies. Some examples are war hazards in this country and abroad; risks covering the nonappearance of an actor or other performer because of accident or sickness (written for the benefit of the employer, not the performer); loss of license by a commercial pilot because of disability; accidents to amateur or professional athletes; risks to human guinea pigs in scientific experiments; and hazards to those concerned with atomic and hydrogen bomb experiments. Any list of perils underwritten by special risk is limited only by the imagination. The special risk underwriter never refuses to consider a case because of the unusual nature of the hazard.

Special risk underwriting and rating are subjective; i.e., they depend not upon statistics of past experience, but upon the judgment of the underwriter. Since the distribution of many like exposures is impossible under special risk insurance, underwriters substitute for it a spread of insurers (mass underwriting) through reinsurance.³⁶

Fraternal. Some fraternal organizations offer accident and sickness benefits to members, usually on a restricted basis.³⁷ It is common for certificates of fraternal coverage to exclude a long list of diseases and disabilities and to pay reduced benefits for still other diseases. Medical expense coverage is rarely found except on a need (charity) basis.

Life Insurance Riders. Life insurance riders offering accident or disability protection are not usually classified along with other health insurance coverages. Since they are written as a part of life insurance policies rather than separately, they are often bypassed in discussions of health insurance. These riders are: (1) Double indemnity for death by accidental means. For a small additional premium, a life insurance policy may carry a rider agreeing to pay an additional amount equal to the face of the policy if death is the result of "accidental means" occurring before the end of the policy year nearest the insured's 65th birthday and within ninety days after the accident.³⁸ Usually, the extra premium for the rider is payable only during the regular premium-paying period, but not beyond the policy anniversary nearest the insured's 65th birthday. The provision does not apply to reduced paid-up or extended term insurance or to additions to the policy paid for by dividends from participating policies. It does not affect the regular cash values of the policy. (2) Waiver of premium. For a small extra premium³⁹ it is common to attach to life insurance a rider providing that in the event the insured becomes

³⁶ See Chapter 2, footnote No. 16.

³⁷ Note the term "usually." Some larger fraternal offer coverages in every way comparable with regular insurance companies. In fact, these fraternal actually have pioneered a number of the coverages now considered standard. The text discussion refers principally to the hundreds of small fraternal societies to whom insurance coverage is only an incidental service.

³⁸ The precise meaning of "accidental means" is discussed later.

³⁹ For the company, the chance of loss involved in the case of waiver of premium

permanently and totally disabled before age 60 (in some companies 65) premiums will be waived for the duration of the disability beyond a specified period, usually six months.⁴⁰ It is commonly available on unmarried, self-supporting women under 45 or 50, and a number of companies will write it on dependent married women. When the premiums are waived by the company, the disabled policyholder continues to receive a full dividend on participating policies. The policyholder's relations with the company with respect to non-forfeiture values, death benefits, maturity values, and dividends are the same as though he had continued to pay premiums from his own pocket

When there is no disability income insurance, waiver of premium in some cases has been used to provide the disabled policyholder with needed cash. The waiver keeps the policy in force and continues to build its cash values. These cash values may be drawn upon by the policyholder for loans. As the policy values increase, the loan may be increased. The use of waiver of premium in this way, however, tends to defeat its purpose, which is basically to keep the life insurance in force when because of disability the insured may be short of funds.

(3) Disability income riders: under these riders the insurer agrees to pay a monthly income, equal usually to one-half of 1 per cent to 1 per cent of the face of the policy, in the event that the insured becomes permanently and totally disabled. This income is paid for the duration of the disability, or until age 65. If the policyholder is still disabled at 65, the face of the policy is payable in a lump sum or under instalment options.⁴¹

Disability income riders are written to cover only *total* and *permanent* disability. *Total disability* is defined as any disability which will render the insured incapable of engaging in *any* work for pay or profit. Although this is a strict definition, courts require reasonableness in its application. The strict-

riders is relatively small (although the loss itself can be costly to the individual). For this reason, rates are extremely low. For instance: on a participating ordinary life policy with one company, disability waiver at age 25 is \$1.20 additional premium per year for each \$1,000 of life insurance. On a twenty-pay life policy in the same company at the same age, it is \$1.02. On an endowment at 65, it is \$1.30 per \$1,000 of life insurance.

⁴⁰ It was customary at one time to charge more for waiver of premium for women than for men, and to terminate the coverage five years earlier. The present trend, however, is to treat women the same as men for waiver of premium, although women still are probably more carefully underwritten.

⁴¹ It may seem contradictory to provide that benefits for a *permanent* disability will be paid *for the duration of the disability*, since it would appear that, by definition, the duration of a permanent disability is for the life of the policyholder. However, case law has held that there need be only a "reasonable assumption" that disability is permanent for it to be so classed. Hence, a disability may be deemed legally "permanent" and yet recovery may eventually be effected. Consider also the implication in the following true story: During the days of the "Great Depression," a merchant was pressing a customer for payment of an account. Finally, the customer wrote asking for an extension of time. He explained, "I expect any time to start drawing permanent disability benefits, temporarily." The story is not a mere joke. This very type of "temporarily permanent" disability, certified by many physicians and upheld by many courts during the depression, broke the back of the disability income and non-cash disability insurance business for a generation.

ness of the definition is designed to protect the company in borderline cases so that the premium rate may be kept as low as possible. Certain disabilities are considered total by their nature. Among these are the loss of sight in both eyes or the loss of the use of both arms or both legs, or of one arm plus one leg. *Permanent disability* is defined as any total disability continuing longer than a period specified in the rider, commonly six months. Accordingly, the loss of both arms is not considered permanent until after the waiting period.⁴²

Disability income coverage under life insurance riders generally terminates at age 55 or 60. Any disability which develops subsequently to that age is ruled out. One who is disabled before that age, however, continues to receive his payments. As a rule, disability clauses are issued only on applicants between the ages of 15 and 50. Some companies have an age limit of 45, whereas others will write applicants as old as 55. A maximum limit on income benefits is established by insurance companies.

When a disability income rider is attached to an endowment policy, the disability income ceases at the maturity of the endowment. Formerly, contracts provided for disability income for the lifetime of the insured, irrespective of the endowment date. The provision was discontinued on the grounds that too many of the insured were using disability income for retirement. Usually, women are not granted the monthly income disability income rider; although some companies will write self-supporting women under, say, age 45 in occupations that take them outside the home daily.

Disability benefits are not payable for disability beginning after a policy is on extended term or a paid-up basis.

New Forms. As this is written, a new form of health insurance has just appeared: disability income with cash values. The form being offered establishes a cash value which is, in simple explanation, a return of the difference between the portion of the policy reserve necessary to carry a level-premium policy to its termination age and that which is necessary to carry it to the age at which the insured "cashes out." The cash value developed follows the same pattern as in term life insurance written to age 65; i.e., the cash value increases from issue age for a number of years (the exact number of years depending on issue age) and then falls fast to zero at termination age.

It is also understood that at least one company has "on the drafting board," policies offering the same nonforfeiture values as are found in life insurance contracts plus paid-up values at termination age.⁴³

5. THE HEALTH INSURANCE POLICY: INSURING AGREEMENTS AND BENEFITS.

While the laws of all jurisdictions require the inclusion in every health insurance policy (with certain exceptions, to be mentioned later) of a set of

⁴² Ridiculous as it seems, this is nevertheless true.

⁴³ Such a form will probably have to surmount the restrictions in some jurisdictions on combination life and health forms.

"uniform provisions" relating to what might be called the "operational conditions" of the policy, the wording and sequence of the insuring agreements, benefit provisions, and exclusions in health insurance policies vary widely. The discussion of insuring agreements, benefit clauses, and exclusions may be divided conveniently between loss-of-income coverages and expense coverages. An attempt will be made to eliminate the duplication which naturally arises from his method of presentation by the liberal use of cross references.

Loss-of-Income Coverages. For convenience of discussion, the authors have elected to refer principally to a loss-of-time policy that they deem more or less typical of the current commercial, non-can or guaranteed renewable, adjustable-premium policy.⁴⁴ Bear in mind that, as stated, the wording and sequence of clauses in other policies may vary widely, but the over-all effect of the provisions of any policy will be approximately the same.

The policy under discussion opens with a "policy schedule" setting forth the essential facts about the coverage offered. policy date, monthly indemnity, principal sum, elimination period, maximum benefit period, premium period, and amount of each premium.

Insuring Clause. Following the policy schedule is the insuring clause, including a statement of the consideration.

In consideration of the application, a copy of which is attached to and made a part hereof, and of the payment in advance of the premiums, the Company will pay for disability of the Insured commencing while this policy is in force and resulting from accidental bodily injuries sustained while this policy is in force and not contributed to by any other cause (hereinafter called "such injuries") or sickness, the cause of which is contracted while this policy is in force (hereinafter called "such sickness"), subject to all the provisions and conditions hereof.

Note that in this contract, as in many life insurance policies, the "consideration" is not only the payment of the premium, but also the application.

PRE-EXISTING CONDITIONS. Note also that the policy does not cover pre-existing conditions: the injury must occur and the sickness must commence *while the policy is in force*. This provision is customary with individual policies. Group policies, however, ordinarily cover pre-existing conditions because the element of antiselection is either eliminated entirely or sharply reduced.⁴⁵ As a precautionary measure, some insuring clauses in individual policies include a "probationary" period. Typical of such a provision is to

⁴⁴ The use of the modifying words, "more or less," is in recognition of the difficulty in typifying any health insurance policy.

⁴⁵ Persons insured under a group contract have little or no choice as to whether or not they are to be covered; therefore, there is little chance that those with adverse health conditions will apply for the coverage more readily than those in good health—as is the case in individual coverage. All eligible employees are automatically covered under a noncontributory plan, whereas under a contributory plan, 75 per cent must participate for the coverage to be effective (cf. Chapter 13).

limit sickness coverage to "sickness contracted and commencing after the first fifteen days from the date of this policy. . . ."

ACCIDENTAL BODILY INJURY VS. ACCIDENTAL MEANS. This policy offers coverage for "accidental bodily injury." It once was the custom (and still is, in some limited policies not subjected to careful underwriting at the time of issue) to specify that injury must be caused by "accidental means." The distinction between "accidental bodily injury" and "injury by accidental means" is subject to widespread misunderstanding, so much so that there is a tendency for courts to ignore the difference between the two terms. Many courts, however, still uphold the distinction. "Injuries caused by accidental means" refers to injuries that result from an act that is unforeseen, unexpected, or unusual. An injury that is itself unexpected but nevertheless follows from ordinary means, voluntarily employed, in a way that is not unusual or unexpected, cannot be the result of "accidental means." For example, a male student decides to carry a coed's trunk up to the fourth floor of the sorority house as a favor to her. In the process, he strains his back. While he has suffered an accidental bodily injury, he has not suffered an injury from "accidental means." A strained back is a probable consequence of carrying a heavy object up four flights of stairs (or one flight, for that matter). Legally, a prudent man is capable of anticipating the possible consequences of any voluntary action he undertakes. However, if in carrying the trunk up the stairs the student trips over a bouffant petticoat left lying on the tread of the third flight and falls with the trunk coming down on him breaking a rib, he has suffered an injury by "accidental means." Tripping over a bouffant petticoat is not a probable consequence of carrying a trunk for a friend, even in a sorority house.

If it appears that the distinction is a fine one, it should be remembered that the courts have also found it so. "Accidental means" is being used less and less.⁴⁶ The principal reason that "accidental means" is disappearing from the accident policy is competition. Some underwriters feel that the companies have gone too far in this respect, since in many cases it is necessary to pay a claim under an accident policy for a loss which is more properly due to sickness.

⁴⁶ However, it is still used in the double indemnity riders written with life insurance. Formerly, some insuring clauses in health policies specified that the injury must be a result of "external and violent" means, sometimes adding, "leaving visible wounds or contusions." Although now virtually extinct in health contracts, this wording is still common in double indemnity riders used with life insurance policies. Court interpretation of the term "violent," however, is liberal. It seems that the size of the force operating on the body is unimportant. The court considers all force violent, including the bite of a tiny insect. The "visible wound or contusion" clause nevertheless is strictly interpreted by the court. For the beneficiary to collect under a double indemnity clause so hedged, the insured must have been in an accident sufficiently violent to have abrasions, bruises, or cuts on his corpse. An exception is made in the case of accidental drowning or of internal injury revealed by autopsy.

INDEPENDENCE OF ALL OTHER CAUSES. Note the phrase in the insuring clause, "not contributed to by any other cause." If a student, while crossing a bicycle tow path on the campus, suffers a dizzy spell and falls in front of an oncoming rider and has a rib broken in the ensuing collision, the "accidental bodily injury" has not been without contribution of any other cause. For another example, consider the case of an automobile driver who has a heart attack, crashes into a tree, and suffers multiple fractures and contusions. His injuries have not been independent of other causes.

The purpose of the "not contributed to by any other cause" provision in accident coverage is to allow the insurer to avoid having to pay a claim under an accident policy for a loss due largely to a health condition underlying a minor or imagined accident. However, in cases where a disease following an accident causes death or disability, courts allow recovery under an accident policy if it can be shown that the injury set in motion the chain of circumstances resulting in the loss, regardless of a contributing or concurrent disease. For instance, if a young man suffers pneumonia following an automobile accident in which he was involved, the contract probably will be held to cover for the resulting disability loss if it can be shown that the disease is the direct result of the accident. The recovery would be based on the "doctrine of proximate cause," which can be defined as follows:

In the event of the concurrence of several causes, the loss will be deemed to have been caused by the dominating peril so long as there exists an unbroken chain of cause and effect between the peril and the loss, whether or not the peril is active at the consummation of the loss.

Effective Date. This policy is effective from 12:01 A.M. standard time on the policy date and at the place of residence of the insured.

Inasmuch as the policy states that injury must occur or sickness commence while the policy is in force, it is necessary to state clearly when the policy becomes effective.

Renewability. The types of renewal or continuation provisions have already been discussed.

An optionally renewable provision can read:

Subject to the consent of the company, this policy may be renewed for any specified policy term by the payment of the premium for such policy term at the company's premium rate in effect at the time of such renewal.

A GR provision can read:

This policy is renewable by the timely payment of the premium herein stated until the renewal date immediately following the insured's 65th birthday at the premium rate then in effect for all holders of this class of policy classified only by sex and date of entry. While this policy is in force, the company cannot change any of its provisions or benefits or attach a restrictive rider.

A non-can provision can read:

This policy is non-cancelable and guaranteed renewable. The insured shall have the right to continue this policy in force until he reaches his 65th birthday by the payment of premiums as provided herein. The first premium is due on the policy date. On the first day of each premium thereafter until the insured's 65th birthday, the premium for such period will be due in the amount specified in the policy schedule.

For women, the ultimate renewal age is usually 60, although some policies offer renewability for women to age 62 when they can elect to start their Social Security old age benefits. Some policies, in anticipation of a lowering of the male age for the start of Social Security benefits, are limiting renewability for men to age 62.

Definitions. Health insurance policies define the various terms about which interpretative questions might arise. Companies prefer to define their own terms rather than leave the definition up to a court.

TOTAL DISABILITY. An important definition is that of total disability. The following is a definition of this term found in a selected non-can policy:

Total disability means the complete inability of the insured to perform the duties of his regular occupation, except that after the indemnity has been paid for sixty months of any continuous disability, then for the remainder of the period of disability after the said sixty months, "total disability" shall mean the complete inability of the insured to perform the duties of any occupation for which he is reasonably fitted by training and experience.

The definition of total and permanent disability under life insurance riders has already been discussed.

Older policies, especially commercial forms, often added the requirement that long-term disability benefits are payable only if the insured is not only unable to perform any kind of work for wages or profit but is also continuously confined to the house. Court decisions over the years modified the definition by holding that absence from the house to see the doctor or go to a hospital for examination does not violate the definition of "house confinement." In fact, many companies finally began adding to the definition some such wording as, "except that absence from the house for brief periods to consult a physician or for examination in a hospital shall not be considered to have interrupted continuous confinement."

Recently, some companies have begun to add after the "regular occupation" clause (often called the "own occupation" definition), some qualification such as, "and does not engage in any occupation for wages or profit." The restriction is intended to eliminate the situation in which, for instance, a surgeon acquires a digital condition that prevents him from performing surgical procedures but allows him to take a position as a hospital administrator at an adequate salary. Without the qualification, "and does not engage in any occupation," he would be in a position to claim benefits for the "own occupation"

period. (Competitive critics claim such a definition is "double talk," making the "own occupation" definition, "any occupation" in practical effect.)

The length of the "own occupation" period in the definition of total disability has been increasing in recent years. Only a few years ago, policies usually defined "total disability" merely as inability to engage in any occupation for wages or profit (modified by case law to "for which reasonably fitted" and now usually so defined in policies). Companies started adding "own occupation" clauses of one or two-year durations. Many policies offered at the present time still confine the "own occupation" definition to two years, and many underwriters will argue that longer periods are not justifiable from an underwriting standpoint. However, a five-year definition is becoming more common and probably will eventually be forced on all companies as a matter of competition. Reasoning from the competitive pattern, it would seem that eventually total disability definitions will confine themselves merely to "own occupation," omitting "any occupation for which reasonably fitted . . ." They may also include "and does not engage in any occupation," unless subsequent litigation ignores that provision so that it becomes inoperative as a practical matter.

It has also been common to provide that "total disability" must include "the regular care of a physician." However, there is case law holding that if competent medical testimony is that the disabling condition cannot be treated or improved by regular medical care, the requirement is meaningless.

PARTIAL DISABILITY. Another important definition may be that of partial disability. Partial disability is defined in one policy as

" . . . inability of the Insured to perform the majority of daily duties of his regular occupation."

Other definitions will word it " . . . inability to perform one or more of the major duties of his regular occupation."

As mentioned, partial disability frequently is written in connection with accident insurance but is not usually written with sickness coverages. Some companies will not write it at all for sickness, whereas others who do not include it in the policy will offer it as a rider for an extra premium.

DISMEMBERMENT. Where a policy covers dismemberment, it is important that this term be defined. "Loss" of limbs is usually defined as "actual severance through or above the wrist or ankle joints," and "loss" of sight is defined as "entire and irrecoverable loss." It will be recalled that, in the definition of total disability in the life insurance disability rider, reference is made to loss of *use* of arms or legs, or one of each. It does not require severance.

ELIMINATION PERIOD. The elimination period is usually defined in a policy as follows:

. . . means the number of days of continuous total disability commencing with the first day thereof, for which no indemnity is payable.

The elimination period reduces claim frequency. Inasmuch as a claim involves administrative costs, the fewer the claims, the lower the administrative cost. The premium can therefore be lowered if an elimination period is written into the policy. The longer the elimination period, the lower will be the premium. The savings in premiums, however, increase at a diminishing rate as the waiting period increases. The drop in premiums between a thirty and sixty day waiting period, for instance, will be less than the drop between first-day coverage and a thirty-day elimination period. Rate reductions for waiting periods beyond ninety days are comparatively minor. Common elimination periods in non-can are thirty, sixty, and ninety days, although longer or shorter waiting periods are available. Some companies will write first-day benefits. First-day benefits are far more common for accidents than for sickness. It is much easier to determine disability on the first day of an accident than on the first day of most sicknesses.⁴⁷

Waiting periods usually are shorter for commercial policies than for non-can. Waiting periods of one or two weeks are popular for sickness, and first-day coverage is popular for accidents.

PHYSICIAN. Many policies find it necessary to define the term "physician." In one policy, he is defined as a legally qualified physician (doctor of medicine or osteopathy) or surgeon (doctor of medicine or osteopathy) other than the insured. In other words, the physician cannot treat himself and collect benefits. Some additional definitions may be found in other policies, but those discussed here may be considered typical and illustrative.

Benefit Provisions. Benefit provisions in loss-of-income policies include two major provisions, one for accidents, another for sickness. The following is an accident provision typical of non-can:

If as a result of such injuries, the Insured suffers continuous and total disability within 30 days of the date of the accident, and requires the regular attendance of a physician, the Company will pay periodically during such continuous total disability the Monthly Indemnity, provided, however, that no indemnity will be payable for the Elimination Period for Accident, nor for any period of disability in excess of the Maximum Indemnity Period for Accident, and provided further, that if such disability commences after the policy becomes renewable at the option of the Company after age 65, the indemnity will not be payable for more than 12 months.

The limitation of benefits to twelve months after age 65 is in recognition of the facts that (1) the morbidity rate climbs rapidly in older ages and (2)

⁴⁷ The elimination period in a loss-of-time policy is comparable to a deductible in a reimbursement policy. Economically speaking, no one should buy insurance to cover losses he can pay out of pocket without financial hardship. It may be "nice" to receive a claim check for a \$7.50 X-ray or for one day of disability, but except in rare instances, it has cost more in premium money to get the benefit than the benefit is worth. Everyone knows someone who has "made money" on his insurance coverage, but such a person is an exception. If he were not, the insurance business could not survive. Insurance itself is not a profit-making venture for the insured. It is a method of transferring the risk of a large, uncertain loss to the certainty of a small, budgetable, expense: the premium.

most business and industry retirement plans, including United States Social Security, begin at age 65. The second fact poses the danger that disability income will be converted by the insured into retirement income. A man aged 65 or over about to be dismissed or retired might be tempted to "acquire" a disability just before leaving his job. If he should do so, at least the company is not committed to long-term benefits. Under the clause, the insurer is still able to offer some coverage to the over-age individual who is still employed and who may suffer a real loss of income because of disability.

Some policies include a provision for non-disabling injury indemnity as follows.

If such injuries shall not entitle the Insured to any other indemnity under this policy, but shall require treatment by a physician, the Company will pay the cost of such treatment in an amount not to exceed one-fourth of the Monthly Indemnity.

The accident indemnity provision typically adds.

Total disability caused solely by such injuries and commencing more than 30 days after the date of the accident shall be indemnified as sickness.

A typical partial disability clause reads:

If as a result of such injuries, the Insured suffers partial disability immediately following a period for which he is entitled to indemnity for total disability and requires the regular attendance of a physician, the Company will pay periodically one-half the Monthly Indemnity for the period of such partial disability, but not to exceed six months during any one continuous disability, and provided that indemnity for total and partial disability combined shall not be payable for any continuous period in excess of the Maximum Indemnity Period. If partial disability shall commence within 30 days of such injuries and require the regular attendance of a physician and there is no Elimination Period for accident, said partial disability shall be payable from the first day.

Some policies (or riders) make partial disability available following sickness as well as accident; but in the case of sickness coverage, they offer it only following a total disability. The sickness benefit clause is usually simply a restatement of the accident indemnity clause, substituting the words, "as a result of such sickness" for "as a result of such injuries."

Policies also frequently make provisions for recurrent disabilities. One such provision is as follows:

If following a period of disability for which indemnity is payable under this policy, the Insured shall resume his regular occupation and perform all the important duties thereof for a continuous period of six months or more, any subsequent disability commencing while this policy is in force and resulting from or contributed to by the same cause or causes shall be considered a new period of disability and indemnified as sickness, but if said period during which the Insured resumes his regular occupation shall be less than six months, such subsequent disability shall be deemed a continuation of the preceding disability, and the Company's liability for the entire period, including such preceding disability or disabilities, shall be subject to the applicable Maximum Indemnity Period.

Assume a policy with a five-year maximum benefit period. The insured has a heart attack. After six months he is able to return to work on a full-time basis. However, if within six months of that return, he suffers a relapse, it will be considered that it is all the same disability. On the other hand, if the relapse does not occur until eight months following his return to work, the relapse will be considered a new disability. The provision protects the company against a situation in which the insured, a month before the end of the maximum benefit period (five years in our example) manages to go back to work for a brief period and then applies for a new five-year benefit period. At the same time, it also assures the man that if he does go back to work but cannot honestly stand the pace he will not have to go through the elimination period again before collecting benefits provided, of course, that he works fewer than six months. This latter effect can be important. For instance, therapy practiced in a heart case often is to try to get the sufferer to return to a life as nearly normal as possible. However, inasmuch as he may have dipped deep into his financial reserves for the period he has been unable to work, he may resist going back to work if, as soon as he does, the policy provides that the current disability period is ended and a relapse will subject him to a new elimination period of no benefits. Further, the provision gives him the incentive to try to go back to work, since if he can "make it" for six months, the maximum benefit period will begin once more should he subsequently have a relapse.

An important benefit in health insurance policies as in life insurance policies is waiver of premium. A typical clause states:

If such sickness or such injuries shall result in total disability, the Company will waive any premiums which become due within said period of total disability, provided said period of total disability shall have continued for a period of at least 90 consecutive days, and will refund any premium which was paid during said 90-day period, provided that no premium shall be waived after expiration of the Maximum Indemnity Period set forth in the Policy Schedule for such sickness or such injuries. Following such a period of disability during which the Company has waived premiums, the Insured shall have the right to resume payment of premiums as they become due.

Waiver of premium is common in disability income policies, but not all of them provide for refund of premiums paid during what might be termed the "waiver waiting period" of ninety days or so. The trend seems to be toward making the refund, principally as a matter of public relations with policyholders.

Many policies provide for accidental death indemnity. An illustrative clause is as follows:

If such injuries shall within 120 days of the accident be the sole cause of the death of the Insured, the Company will pay the Accidental Death Indemnity, except as hereinafter limited, and in addition thereto will pay the amount due as provided under Monthly Indemnity-Accident for disabilities resulting from such injuries, if

any, to the date of death. Where death covered by this part results from asphyxiation or the inhaling of monoxide or other gas or vapor or from poisoning self-administered (except death from suicide or intentional self-destruction, for which no liability is assumed), the amount payable hereunder shall be one-fifth of the Accidental Death Indemnity in lieu of any other indemnity.

The provision concerning asphyxiation and inhalation of gases is a result of the fact that while these are methods often employed in suicide, it is also often difficult to prove they were not accidental—and expensive to prove in court even if the case succeeds. Therefore, a specific benefit is made payable for them so that in case they occur, the company's liability is cut without resultant litigation inasmuch as the company will not contest the claim but will pay according to the policy provisions.

Accidental death is common in commercial policies, which often also include dismemberment clauses as well. Both accidental death and dismemberment are to be found in non-can but less frequently than in commercial.⁴⁸ Further, it seems more common for accidental death and dismemberment to be added to non-can and GR by rider than for the provisions to be contained in the policy. In the non-can and GR lines today, the trend is toward "stripping down" the policy to the basic and most important coverage—loss of income. What have been referred to as "frill benefits," such as accidental death,⁴⁹ dismemberment, non-disabling injury, etc., are then added as riders, if made available at all.

Limitations, Exclusions, and Exceptions. Whereas a life insurance policy usually covers all deaths (except suicide within an initial period stated, or as a result of war and certain aviation perils), a health insurance policy excludes some accidents and some sicknesses. Each policy contains certain limitations, exclusions, exceptions, and reductions. The following list is fairly complete.⁵⁰

⁴⁸ It is difficult to make precise statements using "common to," "more frequently than," etc. in referring to the use of any given policy provision. There are over 1,500 companies in the United States writing health insurance. Each will have a number of policy forms. The authors confess that they have not read the provisions of every policy issued by each of the 1,500 or more companies so that they can state with authority, for instance, that accidental death provisions appear in more policies than not. Actually, the best they can do is say, "Our impression, based on the policies we have studied, is that this or that provision is more common."

⁴⁹ The president of one company told the authors that his company is revising its non-can policy form to "strip it down" and add such benefits as accidental death, partial disability, and non-disabling injury (now policy clauses) as riders instead of policy provisions. In the case of accidental death, the authors repeat a previously expressed philosophy: There seems to be no logic in compensating accidental death in a greater degree than natural death. It is highly probable that all death coverage should be confined to the life insurance policy—until the day is reached when company philosophy and state law recognize that life and health insurance are "income insurance" and issue both (or authorize the issue, in the case of state law) in one policy.

⁵⁰ In addition to the accident exclusions listed below, the double indemnity rider used with life insurance may exclude death from poison or inhalation of gas, riot, and insurrection, or as a result of a law violation by the insured. The life insurance disability rider also may exclude law violations.

Accident Exclusions

- (1) War or act of war, declared or undeclared.
- (2) Accidents suffered while in the armed forces or which occur while the insured is in military service for any country at war
- (3) Suicide, sane or insane, and intentionally self-inflicted injuries
- (4) Aviation accidents, except those of a passenger plane on a regularly scheduled passenger trip over an established line.
- (5) Injuries contributed to by bodily or mental infirmity, hernia, ptomaines, bacterial infection, disease, medical or surgical treatment (except infection resulting from an injury, as blood poisoning from a wound).
- (6) Injuries contracted outside of a given territory.

Sickness Exclusions

- (1) Sickness suffered while in the armed forces ⁵¹
- (2) Sickness for any period for which indemnity is payable on account of accidental injury.
- (3) Pregnancy, childbirth, or miscarriage.
- (4) Illness incurred in the torrid zone (or, in some policies, outside the United States and Canada)
- (5) Disability from mental illness or venereal disease, or both.
- (6) Accidental bodily injury.

Not all these exclusions will be found in every policy, and some others not listed will be found occasionally. The exclusions in one illustrative non-can policy are as follows:

An act of war, whether declared or undeclared, or which occurs while the Insured is in military service for any country at war.

Every policy issued today (that the authors have seen) excepts war and acts of war. Many restrict military service in some such fashion as “. . . while the insured is on active duty in the armed forces of any country or combination of countries (except for brief training periods not exceeding two months).”

Operating or riding in or descending from any species of aircraft if the Insured is a pilot, officer, or member of the crew of such aircraft or is giving or receiving any kind of training or instruction or has any duties aboard such aircraft or requiring descent therefrom.

There appears to be a trend to omit the aircraft exception—as part of an over-all attempt of companies to reduce the number of exceptions and reductions.⁵²

⁵¹ Inasmuch as there is neither loss of income nor cost of treatment if accident or sickness is suffered in the armed forces, it works no hardship on the insured to exclude the payment of these insurance benefits.

⁵² The problem of disability of a commercial pilot, for instance, is a difficult one. If the CAA should declare him unfit for duty by reason of poor eyesight, for instance, he is immediately disabled for pursuit of “his occupation.” Yet it is a fact that commercial pilots currently are generally covered under an insurance contract (with Lloyd’s

Many policies contain geographical restrictions. For instance, to quote a typical restriction, the policy does not cover—

Injury or sickness contracted or suffered outside the States of the United States, the District of Columbia, or Canada, except while travelling temporarily in Mexico for a period up to 30 continuous days on any one visit, unless a travel permit is granted in writing by the Company, nor shall such payment be made to cover any period of disability during which the Insured is outside said territory unless prior permission to reside elsewhere is granted in writing by the Company.

Some policies will refer to the "home area" and then define it as the United States, Canada, and their possessions. Several factors account for this restriction, which does not appear in all policies but seems to be appearing more frequently in the past few years (1) Morbidity rates (because of sanitary conditions) are higher in some countries outside the so-called "home area"—probably a minor factor except for continuous, long-time residence (2) Conditions outside the "home area" are less stable than within it, giving rise to a greater accident hazard. (3) Many areas outside the "home area" are much lower in living costs so that a disability income amount that will provide only a marginal living in the United States or Canada will provide luxury in a foreign area so that acquiring a disability and moving to Spain, some areas of Mexico, etc. could prove financially attractive.

Practically all policies contain the following exclusions—

Any attempt at suicide while sane or insane, or by injuries intentionally self-inflicted. (In accident policies only)

Any sickness commencing or injury suffered after the Insured's 65th birthday, unless this policy has been renewed after age 65 with the consent of the Company.

(Perhaps the majority of policies simply end coverage at 65; therefore, this exception or exclusion would not be necessary.)

Any disability or loss resulting from inguinal, umbilical or postoperative hernia, ptomaines or bacterial infection shall be indemnified if at all as sickness, except that pyogenic infections incurred through an accidental cut or wound shall be indemnified as accident.

The insured shall not be entitled to concurrent indemnities for disability contributed to or caused by both injury and sickness.

of London) that indemnifies them \$25,000 for loss of license for physical reasons. Further, since the contracts of the unionized pilots give them considerable time off, many of them have developed substantial side-line businesses or operations. Sound underwriting insists that no insured have as much income net after taxes from sources other than his occupation as he has while fully employed. If he has, there exists the temptation to "become disabled." A pilot with a profitable side-line business, \$25,000 insurance by reason of loss of license, *and*, say, \$500 a month or more from disability income coverage is in a position tempting disablement, subconsciously if not consciously. (This is not intended to impugn commercial pilots. They are used only to provide a specific example. The same principle applies to any insured persons with a similar combination of circumstances.) However, the pilot situation, to be specific, can be mitigated if the definition of total disability includes under "own occupation" the aforementioned clause or phrase: "and does not engage in any occupation for wages or profit."

Expense Coverages. The two principal types of expense coverages are (1) the basic forms of hospital, surgical, and medical and (2) the catastrophe form known as major medical. Each of these two basic types of policies will be discussed to the extent that they involve principles or provisions foreign to loss-of-income coverages.

Insuring Clause. Both the basic and the catastrophe form include not only the named insured as in loss-of-income coverages but also include "any eligible member of insured's family named in the application." Eligible members of the family usually are restricted to the insured's spouse and the unmarried children of the insured. Age limits are placed on the eligibility of the children. The maximum age usually may be 18 or 21, but the minimum ages vary among policies. It may be fourteen days, three months, or any such minimum to exclude coverage immediately at birth. Policies usually provide that additional new members must be added upon written application of the insured and upon payment of the required premium, if any. Coverage for members of the family usually is not as common in surgical and basic medical expense insurance (non-group) as in hospital expense and major medical policies.

The expense policies contain the same provisions relating to consideration, effective date, and pre-existing conditions as found in loss-of-income policies.

Renewability. Just as in disability income policies, policy forms in expense coverage are available which are renewable at the option of the insured to specified ages. The trend is to extend the renewable option beyond retirement age but to limit the benefits. Whereas disability income benefits generally are not needed after retirement, expense coverage remains important until the insured incurs his final medical expenses.

Definitions. In expense coverages, certain definitions not found in a loss-of-time policy will be found. Typical of these are:

Hospital: A legally constituted and operated institution which has organized facilities for the care and treatment of sick and injured people on an in-patient basis, including facilities for diagnosis and major surgery, a twenty-four-hour nursing service, and medical supervision.

Nurse: Graduate or registered nurse other than one who ordinarily resides in the insured's home or who is a member of the insured's immediate family.

Benefit Provisions. It is in the benefit provisions, naturally, that the expense policies differ materially from the loss-of-income policies. The benefit provisions under the basic coverages and those under major medical are sufficiently different to merit separate treatment.

Basic Hospital Forms. Basic hospital insurance coverages provide for hospital confinement expenses, usually for actual charges for room and board up to a maximum amount per day and for a maximum number of days per hospital confinement.⁵³ A hospital confinement is defined as all periods of hospital confinement separated by less than six months unless due to entirely

⁵³ In addition to the primary benefit period, a few plans offer a reduced benefit for a secondary period.

unrelated causes. Some policies fix the limit as a contract year rather than as a hospital confinement. The limit applies separately for each member of the family. Some few plans pay a fixed-dollar benefit irrespective of actual charges, whereas others provide full coverage for room and board without a per diem limit, but restrict the service to a given class such as semiprivate rooms.

Hospital insurance policies usually cover necessary hospital extras up to a maximum measured in terms of a given multiple of the room and board daily maximum, such as fifteen times the daily rate for room and board when the patient is confined to the hospital for a minimum period such as eighteen to twenty-four hours. The purpose of the minimum confinement period is to eliminate coverage for diagnoses.

Some hospital policies offer coverage for accident emergency treatment where an insured receives emergency treatment in a duly constituted hospital but is not confined as a registered bed patient. The limit is usually a given multiple (commonly three) of the daily room and board benefit, and the treatment must be received within twenty-four hours from the time of the accident.

The hospital forms generally exclude pregnancy, childbirth, miscarriage, or complication from these causes, but usually offer separate maternity benefits. The maternity benefit usually does not become effective until the policy has been in force for ten months and is generally limited to a benefit equal to a given multiple (such as ten) of the daily room and board benefit, payable as a lump sum.

A few hospital forms offer benefits for nursing expenses, some only while the insured is in the hospital, and others extending to nursing care at home.

Basic Surgical Forms. As mentioned earlier, surgical benefits are set forth in a schedule of operations. To be eligible for benefits under a typical individual (as distinguished from a group) form, the insured must have surgery performed while the policy is in force, or during a period for which any other indemnity is payable under the policy,⁵⁴ or within ninety days after the end of the policy term and during a period of continuous total disability which commenced while the policy was in force.

Basic Medical Benefits. The nature of basic medical benefits has already been discussed. No need exists for further elaboration at this point.

Major Medical Forms. The nature of major medical insurance has already been discussed. Because the coverage is still in the experimental stage, the forms have not yet jelled. The benefits provided under one form will be discussed here and an effort will be made to show how other forms might differ.

The benefits may be discussed under six headings (1) the deductible, (2) benefit periods, (3) maxima, (4) co-insurance, (5) covered charges, and (6) specified diseases.

(1) **THE DEDUCTIBLE.** The deductible used in this illustrative policy is

⁵⁴ Remember that individual surgery coverage generally is written as a part of or as a rider to hospital or disability income insurance.

\$500 and is applied with respect to each family member. The policy provides, as is customary in this type of deductible, that if covered charges are incurred on behalf of two or more family members as a result of the same accident, only one deductible amount shall apply to the combined charges so incurred. It is a benefit year deductible in that the company will become liable when covered charges at least equal to the deductible amount are incurred within any period of twelve consecutive months. In some policies the deductibles are applied to each disability rather than allowing the expenses to accumulate over a given period. In other plans the deductibles are cumulative, but over a given calendar year rather than over any twelve-month period. When a calendar-year deductible is used, it may apply to the total expenditure for the family rather than separately to the medical expenses incurred by each member of the family. Some companies write a monthly family deductible plan in keeping with the practice of monthly budgets used by many family units.

(2) **BENEFIT PERIODS.** The policy under examination will pay only those covered charges which are incurred within one year from the date on which the deductible amount was exceeded unless the insured is still confined to the hospital. The deductible becomes operative again at the end of the benefit period. Some policies have benefit periods running for two or even three years. Others dispense with a benefit period and are content to rely on the maximum amount payable to control the liability.

(3) **MAXIMA.** The policy being described here has a maximum limit of \$5,000. This is the limit of liability for each disability. In some plans the maximum limit applies to a calendar year or benefit period rather than to each disability. Other plans have a lifetime maximum known as an aggregate. Such plans commonly allow the insured, if he can prove insurability, to reinstate the aggregate limit after a given amount of benefits has been received. Aggregate limits are more common than annual limits or benefit period limits but less common than a maximum benefit for each disability.

(4) **CO-INSURANCE.** The co-insurance provision in this illustrative policy is 25 per cent, which means that the insurer will pay 75 per cent of the covered charges in excess of the deductible. Some plans are written with 20 per cent co-insurance. A few plans are written without co-insurance, but no co-insurance policies are the exception.

(5) **COVERED CHARGES.** Covered charges in the policy under discussion are the *reasonable* charges incurred by a family member for *necessary* medical or surgical treatment, services, or supplies which have been prescribed by the attending physician or surgeon and which have been furnished directly to such family member. Charges incurred for a wheel chair, hospital-type bed, and iron lung for medical or surgical treatment are covered only if such charges are for the rental of such equipment. Treatment of complications incident to pregnancy are covered, but only for charges in excess of those which would have been charged for such pregnancy in the absence of complications. Certain charges are specifically excluded. These exclusions are treatment for

nervous or mental disease or disorder, unless specifically covered, dental work; eye examinations, glasses; hearing aids, cosmetic surgery or plastic surgery unless necessary because of an injury covered by the policy; travel or transportation, except local commercial ambulance service. Other exclusions which are common to all expense policies are found, but these are discussed in the next section.

Note that this plan covers nearly all types of medical expenses irrespective of hospital admission. Some plans, however, require hospital admission as a requisite for benefits. In some plans the list of exclusions may be larger including, for example, alcoholism and narcotic addiction, whereas in others the list may be smaller.

(6) SPECIFIED DISEASES. The illustrative contract states that if a family member contracts poliomyelitis, spinal meningitis, encephalitis, leukemia, tetanus, multiple neuritis, diphtheria, scarlet fever, smallpox, rabies, elephantiasis, or tularemia after the date of the issue of the policy but while the policy is in force, the company will pay 100 per cent of all covered charges incurred over a three-year period beginning with the date of the first treatment but not in excess of the maximum benefit. In other words, the benefit period is extended to three years and the deductible and co-insurance provisions are waived. Transportation of the patient by regular commercial airline or railroad to a hospital or sanitarium qualified to provide the necessary initial treatment is paid. This coverage is simply the dread-disease coverage which was first written as "polio" coverage. In some contracts the list is smaller, leaving out rabies and tularemia. In others, the list may be longer including cerebral meningitis and typhoid. Some policies may not include this coverage at all but it may be available as a rider.

Limitations, Exclusions, and Exceptions. The expense coverages contain many of the same exclusions as found in the income coverages. These deal with pregnancy, war, mental disorders, aircraft, attempted suicide, and full-time membership in the armed forces. In addition, the expense policies frequently exclude charges incurred in connection with injuries sustained or sickness contracted if the insured is entitled to benefits under any workmen's compensation or similar law, and services and facilities provided by or in a hospital owned or operated by a national government or any of its agencies.

6. THE HEALTH INSURANCE POLICY: UNIFORM PROVISIONS.

About 1909, state legislatures began to study the problem of unduly restrictive claim practices and other abuses in the health insurance business. In order to offset much of this criticism, the National Association of Insurance Commissioners drew up a group of standard provisions for health insurance policies. By 1911 this set of provisions, with some state-by-state variations, was put into law in most jurisdictions; and the requirement was made that any health insurance policy issued in the jurisdiction must contain this set of provisions exactly as worded in the law.

Uniform Provisions. In 1950 the National Association of Insurance Commissioners approved and recommended for adoption in all insurance jurisdictions a set of "Uniform Individual Accident & Sickness Policy Provisions," headed in most policies, "General Provisions" or "Policy Provisions." This set of provisions replaces the "Standard Provisions," which had become less "standard" with the passing years. Developments in the business had made some of the old standard provisions less applicable and these changes had been reflected in variations and amendments in the laws of the various states.

The "Uniform Provisions," however, cover the same general area as the "Standard Provisions," but in a somewhat different order and with changes adapting them to modern health insurance. Unlike the standard provisions which had to be used verbatim, the uniform provisions are to be followed "in substance." There are twelve mandatory provisions and eleven optional ones. Moreover, the law establishes certain regulations involving policy conditions not embodied in the policy provisions themselves. The law does not apply to workmen's compensation, reinsurance, blanket insurance, or group coverages. Disability riders on life policies also do not come under the uniform provisions law. The following is a brief résumé of the content of each provision, preceded by its number and title as give in the model law.

The Mandatory Provisions

(1) Entire Contract; Changes. The policy and endorsements constitute the entire contract. Changes are valid only if endorsed on the policy by an executive officer of the company. An agent cannot waive any provisions.

(2) Time Limit on Certain Defenses.

(a) In the absence of fraud, no misstatement on the application shall void the policy or be used to deny a claim for loss incurred or disability commencing after the policy has been in force three years.⁵⁵

(b) After three years a claim shall not be reduced or denied on the grounds of pre-existing condition.

(3) Grace Period. A grace period shall be granted for payment of premiums. (The period must be not less than seven days for weekly premiums, ten days for monthly premiums, and thirty-one for all others)

(4) Reinstatement. Reinstatement is effected without application if a premium is accepted by the company. If a reinstatement application is required and a conditional receipt is given with such application, reinstatement is automatic if the application is not refused forty-five days from the date of the receipt. A reinstated policy will cover only injuries occurring after the date of reinstatement, and sickness which begins ten days after such date. The reinstatement premium cannot be applied retroactively for more than a period of sixty days prior to the date of reinstatement. (The last provision may be omitted from policies which are guaranteed renewable to at least 50 or for five years after age 44.)

(5) Notice of Claim. Written notice of a claim must be given within twenty

⁵⁵ Optional clause for policies renewable to at least 50 or for at least five years after 44. After policy has been in force three years (excluding any period of disability), it shall become incontestable as to statements in the application

days of the commencement of such loss or as soon thereafter as is reasonably possible. Notice to company or agent with information sufficient to identify the insured shall be sufficient. In case of loss-of-time benefits payable for at least two years, notice of continuation of the disability is required every six months, except for legal incapacity.

(6) **Claim Forms** Claim forms shall be supplied to the insured within fifteen days of the receipt of notice of claim. If claimant does not receive such forms within fifteen days, he will be considered as complying with proof of loss provision (number 7) if he submits written proof of the occurrence, character, and extent of the loss.

(7) **Proof of Loss.** The insured must furnish written proof of loss for loss-of-time benefits within ninety days after the termination of the period for which the insurer is liable, and for any other loss within ninety days after the date of such loss. In case it is not reasonably possible to furnish such proof in ninety days, it must be filed as soon as possible but in no event later than one year unless the insured is legally incapacitated.

(8) **Time of Payment of Claims.** Claims for specific losses will be paid immediately upon proof. Claims for loss-of-time benefits will be paid at periods specified in the policy but never less frequently than monthly.

(9) **Payment of Claims.** Death benefits will be paid to the beneficiary if designated, otherwise to the insured's estate. All other benefits are payable to the insured. This provision may also include the following:

(a) Up to \$1,000 of any indemnity payable to the insured's estate or to a minor insured or beneficiary⁵⁶ may be paid to any relative by blood or marriage deemed by the company to be equitably entitled to it.

(b) At the option of the insured, indemnities for medical, surgical, and nursing services may be paid directly to the hospital or person rendering the service.

(10) **Physical Examination and Autopsy** The insurer shall have the right to examine the insured during pendency of a claim and to perform an autopsy where it is not forbidden by law.

(11) **Legal Actions.** No legal action to collect a claim shall be started sooner than sixty days or later than three years after the time that proof of loss is required to be furnished.

(12) **Change of Beneficiary.** Consent of the beneficiary is not necessary to any changes in the policy unless the beneficiary has been named irrevocably. (Reference to an irrevocable beneficiary may be omitted.)

The Optional Provisions

If the policy covers any subject contained in one of the following optional provisions, then it must use the substance of the provision as set forth in the law. A similar provision which, in the opinion of the state insurance commissioner, is more favorable to the policyholder than the statutory provision may be used instead. Optional provisions (1), (2), and (9) are the ones most commonly used.

(1) **Change of Occupation** If the insured changes his occupation to one more hazardous or is injured or becomes ill while doing anything pertaining to a more hazardous occupation "for compensation," benefits will be reduced to those that

⁵⁶ Or beneficiary otherwise incompetent to give a valid release.

the premium would have purchased for that occupation, subject to the limits fixed by the company for such more hazardous occupation. If he changes to a less hazardous occupation, he may apply for a rate decrease.

(2) **Misstatement of Age.** If the age is misstated, benefits will be those which the premium would have purchased at the correct age.

(3) **Other Insurance with the Same Insurer.** One of the following provisions may be used.

(a) If the insured has other policies in force with the company aggregating more than a specified maximum, the excess shall be void and the premium for it will be refunded to him or to his estate.

(b) If the insured has more than one like policy with the same company, he or his beneficiary may elect which shall be paid, and the premium for the others will be returned.

(4) **Insurance with Other Insurers.** If the insured has duplicating coverage on a service or expense-incurred basis ⁵⁷ with other insurers and fails to notify this insurer, the company's liability shall be the pro rata proportion that the company's indemnities bear to total indemnities under all policies ⁵⁸. The policy may define the nature of duplicating coverage ⁵⁹. If it does not, the provision will not be construed to cover group, medical payment coverage in automobile policies, coverage provided by hospital or medical service organizations, union welfare plans, employer or employee benefit organizations, third-part coverage, or benefits required by any compulsory benefit statute, such as workmen's compensation.

(5) **Insurance with Other Insurers (Covering Other than Expense-Incurred Benefits).** Provision (4) deals with the prorating of benefits in case of duplicating coverage of which the insured has no notice when those benefits are for expenses incurred. This provision applies the same prorating rule to loss-of-time benefits.

(6) **Relation of Earnings to Insurance.** If the loss-of-time benefits under all policies owned by the insured exceed either his monthly pay at the time of disability or his monthly average for the past two years, whichever is greater, the liability of the company shall be for the proportionate amount of such benefits as the amount of the monthly earnings bears to the total amount of monthly benefits, but not less than \$200 ⁶⁰. Premiums paid during the two-year period for the portion not collectable will be returned. A minimum monthly benefit, however, is established. The provision also permits specifying the nature of "other coverages" and declares that in the absence of such specification, the provision shall not be

⁵⁷ "Service basis" policies are those which pay the hospital, physician, or nurse for services performed, such as Blue Cross and other prepaid hospital or medical care plans.

⁵⁸ For example, a policyholder who has two policies, each paying \$200 for a specified accident, would receive only \$100 from the prorating policy because its pro rata proportion to all indemnities covering the same accident is one-half. Premiums for the benefits not payable are returned.

⁵⁹ Such definition is subject to the approval of the state insurance department.

⁶⁰ Assume an insured has two policies containing the above clause, each providing loss-of-time benefits of \$200 a month, or a total of \$400. At the time of disability, he was earning only \$200 a month, and the average of his monthly earnings for the two years preceding was \$185. Since he is currently earning only half as much as the total coverage written, each policy will pay only half the \$200 monthly benefit promised. (How the framers of the model bill could parlay the explanation of this, as they did, into a 500-word provision containing only four sentences, one of which is 250 words long, is a feat that has the authors baffled.)

construed to include the same kinds of coverage listed under provision (4) This provision may be used only in a non-cancellable policy

(7) Unpaid Premiums. Unpaid premiums may be deducted from claim payments.

(8) Cancellation. The insurer may cancel on five days' notice and refund the unearned premium pro rata After the initial policy term, the insured may cancel, effective upon receipt of notice by the company, and receive the unearned premium calculated on a short-rate basis ⁶¹ Cancellation shall be without prejudice to claims arising prior thereto.

(9) Conformity with State Statutes. Any provision of the policy which, on its effective date, is in conflict with statutes of the state in which the insured resides at the time of issue is automatically amended to meet the minimum state requirements.

(10) Illegal Occupation Liability is denied if the loss resulted from the insured committing or attempting to commit a felony or engaging in an illegal occupation.

(11) Intoxicants and Narcotics. Liability is denied for any loss resulting from intoxication or drugs unless administered on the advice of a physician

Other Requirements of the Uniform Provision Acts

(1) The entire monetary and other considerations must be expressed in the policy.

(2) Effective and termination dates must be expressed.

(3) The policy must cover only one person, although it may be amended to include a spouse and dependent children under 19.

(4) The type used in the policy must be at least 10-point ⁶² and must not give undue prominence to any portion of the text.

(5) Exceptions and reductions that are general shall be grouped under a descriptive head.

(6) Only rates, classes of risks, and a short-rate table may be made a part of the policy although not printed therein.

(7) A policy in violation of the Act shall be construed as though it conformed to the Act.

(8) No policy provision can restrict or modify the provisions of the Act.

(9) Statements on the application shall be binding only if the application is attached to and made a part of the policy, and if the insured requests a copy of a reinstatement application and does not receive it in fifteen days, no statements on it shall bind the insured.

(10) Only the applicant can alter a statement on the application.

⁶¹ The short rate provides less than a pro rata refund

⁶² Ten-point is the size of the type used in the body of this book It is one point larger than the type in which this summary of the Uniform Provisions is set, and is two to four points larger than most newspaper type Furthermore, the old Standard Provisions—in effect for some thirty-five years before the introduction of the Uniform Provisions—went so far as to require exceptions, exclusions, and reductions to be set in bold-face type. Thus the old canard about the “fine print” is nothing more than a “gimmick”, and it is noteworthy that critics of “gimmicks” in health insurance often fall back on the use of a “gimmick” in their criticism.

(11) False statements on the application bar recovery only if material to the risk.

(12) Supplying claim forms, acknowledgement of notice of a claim, and investigation of a claim are not a waiver of defense against the claim.

(13) The policy will remain in force for any part of a policy term that goes beyond the age limit, and acceptance of a new premium after that term keeps the policy in force, subject to any cancellation provisions in the policy.

(14) If a misstatement of age leads the company to accept premiums beyond the age limit, liability is limited to a refund of premiums

(15) The Act does not apply to workmen's compensation, reinsurance, blanket or group, life policy riders, or annuity riders covering permanent and total disability.

The insurer, with the approval of the commissioner, may omit or modify any provision inapplicable to or inconsistent with the coverage provided in the policy.

The Application. The application which forms a part of the policy generally asks for the usual personal information for purposes of identification; it also asks for a description of the type of plan for which the application is made and the name of the beneficiary, if any, of the insurance. Moreover, the application searches for information about other insurance, declined applications, and the health and accident history of the applicant. For use in the underwriting of loss-of-time benefits, the application sometimes asks about the applicant's monthly earnings.

The applicant is requested to sign the application, and it is on the basis of these questions that the policy is issued. He certifies that he has read the answers and that they are correct⁶³ and agrees that recovery shall be barred if misstatements material to the risk are made with intent to deceive.⁶⁴

The application usually states that the insurance will not take effect until there has been settlement for the premium and the policy has been issued as applied for. As with life insurance contracts, the policy generally goes into force on the date of the application if the first premium is paid with the application and the insured is an acceptable risk; otherwise, it does not go into force until the first premium is paid on delivery of the policy while the insured is in good health. If the settlement is partial, the policy will remain in force for a pro rata fraction of the original period.

⁶³In view of the importance of the statements on the application, the applicant himself should fill it out. As a practical matter, however, since the applicant is unacquainted with the form, and the form must be filled in so it can be photostated, it is universally the practice for the agent to ask the applicant for the answers and then write them on the form himself. Some applicants do, but no applicant ever *should*, sign the application without reading the questions and the answers filled in by the agent. The authors wish to explain that this advice is no reflection on the integrity of agents. Anyone who has ever dictated to a stenographer knows the mistakes that can creep into the transcriptions of even the best shorthand operator.

⁶⁴It is remarkable what a "poor memory" many applicants have when it comes to health history; and it is interesting how many applicants who obtained the policy by fraudulent concealment of details of poor health history will cry "fraud" at the insurer when claim is denied.

Attached to the application is an authorization to any physician to give medical information concerning the applicant to the company or its representative. The requirement of medical examinations for non-cancellable policies depends upon factors such as the type of plan, the amount of the insurance, and the age of the applicant.

7. HOSPITAL CO-OPERATIVE PLANS.

Co-operative health insurance plans are set up by employees' associations, employers, unions, consumer groups, student groups, hospitals, medical associations, and medical clinics. They are frequently termed "nonprofit" plans because they are usually organized under laws exempting them from certain taxes imposed on regular insurance companies. It may be argued, however, that these co-operative plans are no more "nonprofit" than a mutual insurance company. Chief among these plans in size and extent of operations are Blue Cross and Blue Shield.

Blue Cross. The "Blue Cross Plan" is a name commonly applied to any of the various hospital service plans offered in different localities and loosely co-ordinated at the top by the Blue Cross Commission. The Commission, however, has little authority except to establish suggested standards and provide guidance to those individual plans which recognize it.⁶⁵

Blue Cross is a system of providing hospital service and care as opposed to paying direct cash reimbursement or indemnity benefits to the insured. Hospitals agree to provide Blue Cross enrollees with given types of services at predetermined contract prices. The hospital is then reimbursed by the plan to the extent that the services used are covered by, and expenses incurred are within the limits of, the plan.⁶⁶ Blue Cross plans are usually established on a group basis, although individual enrollments are available in some plans and community enrollments are encouraged.

Blue Cross policies vary considerably from one hospital association to another, and even within a given association there may be some variety as to depth and breadth of coverage. Rates for identical coverage will vary by locality since hospital costs differ by locality. Blue Cross plans usually limit hospital accommodations to semiprivate rooms, since the current practice among hospitals is to charge the private-room patient more for all services, drugs, and dressings than is charged the ward or semiprivate patient. However, Blue Cross plans will make a per diem allowance on a private room.

The Blue Cross enrollee must be admitted to a hospital co-operating with the plan in order to have expenses covered up to the policy maximum. However, when he must be hospitalized in a nonplan hospital, he is allowed a stated dollar per diem.

⁶⁵ Contrary to common public impression, the Blue Cross plan is not one plan on a national basis but is composed of a host of plans independent of one another using only the common name "Blue Cross"

⁶⁶ Limits are usually in terms of the number of days of service rather than dollar amounts.

Blue Shield. "Blue Shield" is the general designation of the Association Medical Care Plans offered as a "running mate" with Blue Cross. A Blue Shield plan may be either a group practice plan or a medical prepayment plan. Under the group practice plan, the enrollee selects his physician from a list of those participating in the plan, and medical care of given types and up to scheduled maxima is supplied. Under the medical prepayment plans, fees within certain limits and up to specified aggregate amounts are paid to any physician or surgeon selected by the subscriber. Blue Shield plans sometimes provide that fees up to aggregate maxima over a given period will be paid in full for those subscribers who earn less than a given wage level. For subscribers earning above those levels the physician may charge an additional fee.

Such arrangements have not proved entirely satisfactory. Often the wage level set for full payment is unrealistically low; or the additional fee the physician charges above the minimum wage level is so great as to lead the subscriber to question whether his premium has really bought anything.

In addition to individual health insurance coverages, group insurance is available. This is discussed in detail in Chapter 13.

8. SUMMARY.

Protection against expenses and loss of income resulting from accidents and sickness is one of the most essential of all insurance needs. The American public has only recently been awakened to this fact. As a result, the health insurance business is growing by leaps and bounds.

The prospective purchaser of health insurance is faced with a great array of policy forms. One researcher found 300 different contracts, no two of which were identical. Fortunately, however, most policies may be classified into several basic categories by coverage offered. In addition, policy forms available to individuals may be classified into commercial, industrial, non-cancellable, guaranteed renewable, and limited. There are also special risk contracts and disability riders on life policies.

Commercial policies generally are restricted to insured persons who are in business and professional work presenting no extreme occupational hazard. Typical of the occupations included in these classes (A through D in one classification manual) are bank clerks, college teachers, college students, professional billiard players, chefs, nurses, college athletic coaches, barbers, and insurance salesmen. Most of the personal accident and sickness insurance sold is to these types. Benefits generally are liberal, and the policies contain relatively few restrictions and exclusions.

Commercial policies cover every conceivable combination of benefits to suit the needs and whims of the buyer. The typical, liberal, broad-form policy will cover accidental death and dismemberment, medical expenses for accidents, weekly indemnity for total disability caused by accident or sickness, partial disability due to accident, hospital and nursing costs, and a specified surgical indemnity schedule. For example, a policy might provide.

\$5,000 for accidental death and dismemberment with certain dismemberments graded downward to \$1,250.

\$25 weekly for total disability, lifetime for accident, starting immediately; one year with two-week waiting period for sickness

\$10 weekly for partial disability, twenty-six weeks maximum, *accident only*.

\$500 blanket for physician's or surgeon's fees, hospital charges, nurses' fees, *accident only*.

\$12 50 weekly for hospital and nursing cost for a period not exceeding twenty weeks, *sickness only*.

\$100 maximum surgical indemnity schedule, *sickness only*.

The cost of this policy varies as between companies and occupational classifications. Illustrative of premiums for the above policy is \$67 annually for a college teacher (Class A) and \$92 for a college athletic coach (Class D). These are illustrative premiums only. Any variations from them should not be considered evidence of extortion or philanthropy on the part of the company quoting them. The above benefits, of course, may be substantially increased by payment of a higher premium.

Some companies issue industrial policies to people in occupational classes more hazardous than those covered by commercial policies. Industrial policies usually carry scheduled rather than blanket medical provisions and provide a lower scale for all benefits than does the typical commercial policy. For sickness benefits they often require house confinement. Sometimes they provide for one-half of the regular benefit for total disability not house-confining. The rates for industrial policies are considerably higher because of the occupational hazard than those for commercial policies. Industrial risks written to exclude occupational accidents usually can be written at Class A commercial rates.

Industrial policies often are written on a weekly premium basis.

Non-cancellable policies are those contracts which grant the insured the right to renew at a guaranteed premium to a specified age, usually 65. They are more expensive, require higher underwriting standards, and may have longer waiting periods for sickness benefits. Guaranteed renewable, adjustable-premium contracts are a relatively new form of coverage and promise to increase greatly the proportion of health policies issued without the right to reunderwrite. Non-can and GR are still currently behind the market in terms of premium volume. However, there has been a marked increase in the volume of GR business written in the last few years. Many companies have entered the field, including some of the large life companies, and all companies are under great pressure to relinquish the right of reunderwriting and to offer health insurance with renewability guaranteed, either with or without the guarantee of premium rates.

Limited policies ⁶⁷ restrict themselves to the coverage of certain accidents

⁶⁷ All insurance policies are limited. There is no such policy as an all-risk contract, although the market is flooded with such policies in name.

or diseases specified in automobile accident policies, travel and ticket policies, newspaper policies, dread-disease contracts, and the like. The cost of these policies is in keeping with their restrictions.

Special risk policies are those that cover the unusual hazards where the chance of loss is not statistically measurable. Each case is written on its own merits and the policy is tailor-made. Examples of special risks are accidents in connection with participation in races, athletic events, and experimental projects.

Life insurance riders include waiver-of-premium benefits and monthly income benefits for permanent and total disability. They also include double indemnity benefits for death resulting from accidental means.

An important development in health insurance is *major medical*. This type of contract is written with a deductible and with a fixed maximum benefit. It is customary to require the insured to bear 20 per cent to 25 per cent of the loss over and above the deductible. This type of policy is well worth consideration; it represents true insurance, as it eliminates small losses.

Hospital care insurance is available on a service basis from co-operative hospital organizations, the most common of which is widely known as "Blue Cross." Medical expense coverage is available through Blue Cross' running mate, "Blue Shield." These organizations compete with regular insurance carriers for the hospitalization and medical expense insurance market, but they do not write disability income coverages or major medical policies.

Although the health insurance business is strictly regulated and the policies issued contain a number of mandatory and optional provisions, the buyer needs to choose his coverage wisely.

QUESTIONS FOR CLASS DISCUSSION

1. Which are more indicative of the need for health insurance, the statistics on the *severity* or those on the *frequency* of accident and illness?
2. Twenty per cent of the illnesses account for more than 50 per cent of the medical bills of the country. Does this statistic offer any suggestion to the prospective buyer of medical care insurance?
3. How do you account for the rapid increase over the past years in the amount of health insurance written in this country? Why has hospital insurance grown faster than disability income coverage?
4. In an attempt to discourage government health insurance, there is a tendency for industry spokesmen to quote figures showing how many people are covered by private insurance. Do these figures give a complete picture of the status of health insurance protection in this country?
5. Are the benefits payable usually more liberal under accident insurance or under sickness insurance? Why?
6. In commenting on major medical insurance, one authority stated that there is

a question “whether the primary purpose of any kind of health insurance plan is to cover financial losses essentially or, on the other hand, to encourage early diagnosis and care, and by such preventive measures reduce the ultimate volume of sickness and its attendant costs.” Comment on this observation.

7. Can a person obtain a comprehensive health insurance program from Blue Cross plans? What would you consider to be a comprehensive health insurance program for yourself?
8. Even though states require uniform provisions, how can you account for the variety of health insurance contracts?
9. A friend of yours asks if the health insurance policy offered to him by the Country-Long Insurance Company is a good policy? What would you need to know about him, the policy, and the company to give him an answer?
10. If you were to buy a major medical policy, explain how you would like to have it written in terms of its deductible, benefit period, maximum, and co-insurance.

CHAPTER 12

Industrial Life Insurance

Both the life and health business have several branches. In the life field, they are industrial, ordinary, and group.

Up to this point, the discussion of life insurance has been concerned primarily with ordinary; i.e., insurance purchased in face amounts of \$1,000 or more with premiums paid at an office of the company. This chapter is concerned with industrial life insurance, which issues policies for less than \$1,000 and collects premiums on them at the home (or place of business) of the insured on a weekly, and sometimes monthly, basis.

1. DEFINITION.

A precise definition of industrial life insurance is difficult inasmuch as it means different things to different companies, especially in the area of monthly-premium policies.¹ In a model law drafted by the National Association of Insurance Commissioners, industrial life insurance is defined as

. . . that form of life insurance, the policies for which include the words "Industrial Policy" as a part of the descriptive matter, and (a) under which the premiums are payable weekly, or (b) under which the premiums are paid monthly or oftener, but less often than weekly, if the face amount of insurance provided in such policies is \$1,000 or less.

Industrial insurance is issued in small amounts, usually in less than \$500 face amount, with premiums collected at frequent intervals at the door. The most common premium interval is weekly, although, as indicated, monthly-premium industrial is issued. Industrial premiums are expected to be paid to an agent who calls at the door rather than being mailed to the company office, as in the case of ordinary.

While there has been some tendency in recent years toward pricing and

¹ Some of the largest industrial writers now issue monthly-premium ordinary in amounts of less than \$1,000. Thus some monthly-premium business that formerly was classified as industrial is now classified as ordinary. Inasmuch as the largest industrial companies (Metropolitan, Prudential, John Hancock) are among those so classifying monthly-premium business, the apparent rate of growth of industrial has been affected. Also, the switch to the ordinary columns of much of the new monthly-premium business has resulted in these companies losing their ranking as one-two-three leaders in production of new industrial

proposing industrial insurance in terms of face amount, as is done in the case of ordinary, traditionally the quotations in rate manuals have been in terms of amount of weekly (or monthly) premium. The sale is of a five-cent-a-week, ten-cent-a-week, etc. policy as contrasted to the ordinary practice of selling a \$1,000, \$2,000 policy, etc. The result is odd amounts of insurance.

The term "industrial" originally developed because historically the insurance was intended to be sold to workers in industry—primarily hourly wage workers. Today the term is somewhat confusing because many an industrial policy will be found in the insurance portfolio of commercial employees and professional personnel.

Over 100,000,000 industrial policies are in force in the United States, amounting to a total of nearly \$40,000,000,000. Industrial life insurance comprises slightly under 7 per cent of the total life insurance in force in this country. The size of the average industrial policy is about \$390.²

The first industrial policy was issued by Prudential of England on November 13, 1854, and the first claim was paid on January 4, 1855. The introduction of industrial insurance in the United States was made by the namesake of the Prudential of England, the Prudential Life Insurance Company of America, organized in Newark, New Jersey, in 1875, as the "Prudential Friendly Society." The Metropolitan and the John Hancock followed the Prudential four years later.

For many years, the only insurance available on the lives of young children was that obtainable through industrial companies.

2. INDUSTRIAL POLICY CONTRACTS.

Types of Contracts. Industrial offers many of the same types of policies found in ordinary. The range is narrower but the present tendency is toward an increase in the number of forms. Whole life paid up at 65 or 75 is more common than whole life paid up at 85 or continuous-premium whole life. Twenty-pay life is also a common form. Twenty-year endowment policies were once popular for children; however, many companies have stopped issuing short-term endowments on a weekly premium basis, offering them, instead, on the less expensive monthly premium plan.³

The scarcity of continuous-premium whole life and especially term forms might be considered unfortunate since in theory, at least, the purchasers of industrial are those who cannot afford the premiums on policies of \$1,000 or more. One principle of insurance buying is that when dollars available for life insurance premiums are extremely scarce, they should be used to purchase as much premature death protection as possible unless extenuating circumstances rule this principle inapplicable. Obviously, the limited-payment and endow-

² This figure compares with about \$3,400 for ordinary and \$3,900 for group.

³ Industrial endowments are prohibited in New York, although monthly-premium ordinary may be written on an endowment plan for amounts less than \$1,000, provided dividend options and policy loan provisions are eliminated.

ment plans common in industrial insurance do not buy as much face amount per premium dollar as could be purchased under one of the term plans.

Industrial insurers probably would argue that extenuating circumstances do rule out the above principle. They would say that for a large number of people, weekly premium life insurance is the only form of savings the policyholder has and that term would eliminate this important savings feature. Actually, the endowment form was introduced in 1892 and sold mainly as a savings plan. They also would contend that the industrial buyer is so governed psychologically that he would not buy any insurance which fails to offer "living benefits." Finally, they would recall that for the most part, industrial policies first issued in the United States were continuous-premium whole life. Limited-payment policies were introduced later because it was found that the burden of continuous payments in late years was too heavy for the typical industrial policyholder of that time.

As to the two sides of this argument, the conflict seems to be between what a man should do as against what he will do.

Policy Provisions. In general, the principles involved in, and the provisions of, the industrial policy are similar to, if not identical with, those of the ordinary contract. However, there are a number of important differences, most of them a result of the special nature of the business, the small size of policies, and the type of customers served.

Because of the small amounts of insurance involved, the industrial policy cannot economically offer some of the options found in ordinary. On the other hand, these small amounts make it possible to offer a greater degree of liberality in some provisions of industrial than can be offered in ordinary. The following are the major differences usually found:

Loan Values. Loan values generally are not provided in weekly-premium industrial policies. Since the face amount is small, the loan value also would be small, and the cost of servicing policy loans would be disproportionate to the money involved. Monthly-premium industrial policies, however, grant loan privileges subject to a minimum amount, customarily \$10.

Assignment. General assignment of the industrial policy is usually prohibited. Assignment to a bank is usually permitted, however, thus making it possible for the industrial policy to be used as collateral. The bank assignment clause is a requirement of the New York State law.

Optional Settlements. Again because of the small amounts of insurance involved, industrial policies usually do not provide for settlement options. Sometimes limited options are found in monthly-premium industrial policies issued for a face amount of \$500 or more.

Dividend Options. Participating industrial policy dividends usually begin not later than the fifth year on weekly-premium policies and not later than the end of three years on monthly-premium contracts. It is uncommon to find dividend options. Dividends are paid annually and on one basis only, usually

as paid-up additional amounts of insurance, or, less often, as a premium credit.

Nonforfeiture Provisions Extended term insurance is available as early as six weeks in policies of some companies and after six months in others. After three years of premium payment (in some companies, five) the industrial policy usually gives the insured the other nonforfeiture options: a paid-up policy for a reduced amount or cash. Ordinary policies usually offer these options at the end of two years. Since values are so small in industrial policies, the choice of nonforfeiture provisions is withheld until the end of the third year because the expense of paying them—in contrast to granting extended term—would be disproportionate to the values received.

Contestability. The application usually is not made a part of the industrial policy, so there is little to contest. Nevertheless, an incontestability clause is included which makes the policy incontestable after it has been in force for one year during the insured's lifetime. A two-year contestable period is customary in ordinary. The policy usually provides a basis for contest by providing that if the applicant receives treatment for a serious physical condition within the two years prior to the application, failure to report such treatment is grounds for rescission.⁴

Suicide. Because the amount of insurance involved in an industrial policy is small, it is not deemed necessary to include the usual suicide clause found in ordinary.

Reinstatement. The industrial reinstatement clause is more liberal than that found in ordinary in that upon reinstatement, defaulted premiums may be paid without interest. It is less liberal in that the reinstatement period is shorter—two instead of three years. Companies' practice in reinstatement is even more liberal than the actual terms of the clause. In some companies industrial policies in force more than five years and premiums not more than six months past due may be reinstated without evidence of insurability.⁵

Some insurers allow premiums in arrears to be made a lien against the policy, thus relieving the policyholder of the burden of paying cash at the time of reinstatement. Interest is charged on the amount of the lien.

Change of Plan. Usually, the industrial policy contains a provision allowing the insured to change from the more expensive weekly premium plan to

⁴ The applicant is not expected to judge the seriousness of a condition for which he has been treated but only to report all treatment. Assume that he fails to report a visit to his physician ten months before application. If it turned out this treatment was for a common cold, it would hardly justify contest; however, if it turned out to be for, say, a malignancy, the failure would be grounds for contest. The burden of proof of lack of seriousness (and materiality) of an unreported treatment is on the insured or his beneficiary, since the insured is obligated to report all treatments, leaving the company to form its own conclusions about the situation.

⁵ Other companies allow reinstatement without proof of insurability regardless of the age of the policy as long as the period of lapsation does not exceed a given minimum. Even the two-year limit on the reinstatement period frequently is disregarded, but interest is charged from the second year on for the past-due premiums.

the less expensive monthly premium plan. Some companies also will allow a change of several industrial policies to ordinary. The technical procedure in such a change is to shift the reserves from the industrial policies to the account of an ordinary policy issued in an amount equal to the total of the converted industrial policies. The premium rate for the new ordinary policy will be established on the basis of an age of issue would have produced the amount of reserve established as of the date of conversion. It follows, therefore, that the higher the reserve, the earlier the assumed issue age will be and consequently the lower will be the new premium.

Grace Period. The grace period is usually four weeks on weekly premium plans and thirty-one days on monthly premium plans.

Beneficiary Designation. Originally, industrial policies did not provide for the designation of a named beneficiary. Instead, the policy, under a facility of payment clause, was payable to anyone who appeared to be entitled to the proceeds as evidenced by possession of the policy or by proof of having paid the funeral expenses. The New York law now restricts this type of beneficiary arrangement. So in most industrial policies issued today, the insured may name a beneficiary, although the company has the right to disapprove a designation (original or change) if no insurable interest appears to exist. To take care of special situations that might arise, industrial policies still retain a modified "facility of payment" clause. The following is an example of this clause as it appears today:

Such insurance shall be paid to the beneficiary, if any, last named in this policy, provided such beneficiary shall (1) be of age and legally competent and (2) surrender this policy with due proof of death within thirty days after the date of such death; otherwise the company may make payment to the insured's estate or to any connection of the insured by blood, adoption, or marriage, appearing to the company to be equitable entitled to it by reason of having incurred expense on the behalf of the insured for maintenance, medical attention, or burial

Thus the clause provides that if the beneficiary does not survive the insured or if the beneficiary is a legal infant, or legally incompetent, the company may pay the proceeds to any relative of the insured who appears to be equitably entitled to them. The clause avoids the cost and delay involved in the appointment of an administrator or guardian.

In addition to the clauses described above which are also found with some variation in ordinary, the industrial policy usually contains a number of provisions not customarily found in ordinary:

Death by Accidental Means and Dismemberment. Double indemnity for death resulting from accidental means, available as a policy rider in most ordinary contracts, is included in all industrial policies and is automatically charged for in the premium. Also included is a dismemberment provision. Loss of two limbs or total loss of sight carries a lump sum benefit equal to the face of the policy, and the policy will be endorsed as paid-up insurance for the full

amount of the policy. Loss of one limb or one eye entitles the insured to a benefit equal to one-half the face and a paid-up policy for the full amount.⁶ Unlike ordinary, no age limit is placed on this benefit. If an accident causing loss of a limb also causes death, the loss of limb benefit will be an offset against the double indemnity benefit.

"Money-back" Option. Industrial policies contain a clause allowing the insured to surrender the policy within the first few weeks (commonly two) and receive a refund of all premiums paid, i.e., he is not charged for the cost of the insurance protection he has received during the "approval" period.

Premium Reduction. Many industrial policies provide that if the insured pays the premiums to an authorized company office rather than to the house-to-house agent, he will be entitled to a refund of, say, 10 per cent at the end of the year. Some companies allow the policyholder who pays the premium directly by means of a money order to deduct the cost of the money order.

Differences in Underwriting Practices. Several underwriting practices differ as between industrial and ordinary.

No Medical Examination. Industrial policies do not usually require a medical examination. A medical examination is sometimes required at older ages, if the amount applied for warrants it, or if the application reveals a need for it. Even when required, the medical is usually both less intensive and less extensive than that given in ordinary insurance. The amount of insurance involved is too small to warrant expensive underwriting costs.

Range of Standard. Many applicants who would be accepted for ordinary only at extra rates qualify for industrial at standard rates. Again, the small amount-at-risk makes for liberal underwriting standards, especially since the premium rates allow for higher mortality costs.

Insuring Age. The age for the purpose of determining the premium for an ordinary policy is the age *nearest* the birthday.⁷ For industrial, it is the age *next* birthday. This, of course, works in the insurer's favor in some cases and further widens the premium differential between industrial and ordinary.

3. PREMIUM PAYMENT AND COLLECTION.

Industrial Field Organization. The differences between premium payment and collection methods of the industrial and the ordinary branch are so extensive as to create a noticeable difference in field organization. In industrial the field is divided into districts organized on a geographical basis. In less populous areas each may cover several small towns; in large cities each may cover only one neighborhood. The objective is to form a district which will

⁶ A payor benefit, under which premiums payable until the child reaches age 21 or so are waived in event of the death of the father, is available for an additional premium, as in ordinary juvenile policies.

⁷ The authors contend that since one can be between only two birthdays at any given age, the term should be, "age *nearer* birthday." However, when it comes to trade argot, the better part of valor is to ride with the tide.

require the smallest amount of traveling time, and hence maintain the highest possible ratio of collections per field hour. A manager is placed in charge of each district. His title is usually "district manager." He corresponds to an ordinary branch manager. He supervises the work of the assistant managers and agents. The assistant managers, sometimes called superintendents, help the manager in the selection and training of men, help the men in canvassing for new business and conserving the business already on the books, settle death claims, and check agents' account books. The assistant manager is usually paid a salary, plus an overriding commission on the new business written by his men, plus an allowance for persistence of new business and the conservation of old business.

The industrial life insurance agent, commonly called a "debit man," is charged primarily with the duty of collecting premiums on the "route" assigned him, even though the industrial policy contract carefully specifies that the premium is payable at the home office and that it only *may* be paid to the agent.⁸ Secondly, it is the duty of the industrial agent to sell new industrial and ordinary policies, on which he receives a commission. He must also service policyholders on his debit as new developments in family situations occur or as claims arise.

Each new industrial policyholder receives not only his policy, but also a receipt book, and it is the duty of the industrial agent to sign this book each time he collects the premiums. He, in turn, has a "debit book" in which are recorded the names and addresses of policyholders and the amount they owe per week. This is the agent's account book, which should correspond always to the receipts in the policyholder's receipt book. "Spot" checks by inspectors at a regular interval audit the agent's accounting.

A "debit" is the sum of the premiums an agent is required to collect each week. A debit may consist of as many as 1,000 or even more policyholders. The debit book changes each week as surrenders and claims are deducted and new business and revivals are added. The debit work of the agent is expected to be completed by Thursday morning so that the rest of the week can be spent canvassing for new business. In most agencies, the policies written by an agent outside his own territory are transferred to the agent in whose territory they are written, in order to control collection cost. Usually an agent receives as many new policyholders by the transfer system as he loses; so there is little objection to the plan.

4. COST OF INDUSTRIAL INSURANCE.

There is much misunderstanding about the cost of industrial insurance. This form of insurance has been more widely criticized and maligned than any other branch of the industry.⁹ Because the cost is demonstrably higher to the

⁸ If the agent fails to collect the premium, the policyholder is still held responsible for paying it to the company within the usual four-week grace period.

⁹ See *Investigation of Concentration of Economic Power, Temporary National Economic Committee*, Monograph 28, 1940, and Monograph 28A, 1941.

policyholder, critics have implied that companies make excessively large amounts of money on industrial policies at the expense of the lower-income groups for which they are primarily written. Actually the high cost of industrial insurance can be explained on grounds other than excessive profits.

Premium Comparisons. It is difficult to make an accurate comparison of industrial and ordinary premiums. Industrial premiums include dismemberment disability benefits and double indemnity benefits for deaths arising from accidental means, as described previously, ordinary premiums quoted do not include them. The comparison cannot be validated by the simple addition of the disability and double indemnity rates to the ordinary rate, since the disability clause attachable to the ordinary policy is much more liberal than that included in the industrial contract. Dividend rates also vary between ordinary and industrial so that comparative gross rates do not tell the true story. For example, in one major participating industrial writer, the industrial rate for a twenty-payment life issued at age 25 is quoted at about 19 per cent higher than the same contract issued as ordinary. In a major non-par writer, the difference between these two contracts is almost 28 per cent.¹⁰ Comparisons made at other ages and with other types of contracts will show different figures. These comparisons given here are intended only to show that comparisons on the basis of *gross* rates show results entirely different from those based on *net* rates. Comparisons made with non-par contracts tend to be somewhat more accurate since they eliminate one more variable, the dividend.

The 28 per cent differential quoted above, however, is not to be taken as a naked statement that industrial insurance costs 28 per cent more than ordinary insurance. In fact, a study by the New York State Insurance Department indicates that, on the average, industrial is 15 per cent more expensive than ordinary, and that two-thirds of this difference could be wiped out by paying premiums at the office of the company, leaving industrial only 5 per cent more expensive than ordinary. The differences, of course, vary widely among companies.

Cause of Higher Premium. The higher premium rates of industrial insurance result from three factors: (1) higher mortality costs, (2) higher cost of administration, and (3) higher lapse rates.

Higher Mortality Cost. In the past the mortality of industrial policyholders has been much higher than that of ordinary, especially at the younger ages. One study reports that industrial mortality is half again as high at ages 16 to 40, but only 14 per cent higher at all ages combined.¹¹ Current industrial death rates are about on a par with those of the general population of the United States.

Two reasons for the difference in the industrial and ordinary mortality

¹⁰ The cash values of these industrial policies, however, will be close to 9 per cent higher than the cash value of the ordinary contract at the end of twenty years.

¹¹ H. A. Lachner, "Recent Trends in Industrial Life Insurance," *Insurance Lecture Series*, Storrs, Conn., School of Business Administration, University of Connecticut, 1954, p. 46. However, the industrial death rate has been improving faster than the ordinary so that mortality rates of the two forms are tending to converge.

rates are: (1) Industrial is sold to lower-income groups whose working conditions, living standards, and health facilities have not, in the past, been equal to those of the average ordinary buyer. The difference in the standards of the two groups, however, gradually is becoming less pronounced, and this is one of the reasons why industrial mortality rates are decreasing faster than those of ordinary. (2) As previously mentioned, companies set up less rigid selection standards for industrial than for ordinary. Medical selection is the exception in industrial, and the range of insurability at standard rates is greater than in ordinary.

Higher Administration Cost. The administration cost of industrial is higher than for ordinary. (1) Since the amount of insurance per policy is much smaller, the fixed costs involved in issuing a policy naturally will be higher for each dollar of insurance. (2) It costs money to handle a premium. Whereas the ordinary premium may be handled once, twice, or four times a year, the industrial premium will be handled fifty-two times. The expense of door-to-door collection also adds to the handling costs. A study of the costs of one large industrial writer indicates that about 90 per cent of the excess of industrial over ordinary costs is due to the additional service of collecting premiums in small amounts, at frequent intervals, and at the door. Operating expenses from 1939 to 1943 took 19.5 cents of the premium and investment income dollar in industrial, while taking only 11.3 cents in ordinary. Service expenses accounted for almost the entire 8.2 cents difference. In ordinary, field expenses accounted for 7.3 cents of each dollar; in industrial, these expenses took 15.4 cents.¹² Another study indicated that the expense charge on weekly premium policies collected at the door exceeded that for monthly premium ordinary by about 13 per cent.¹³

Lapse Rate. The lapse rate of industrial insurance is higher than that of ordinary. The higher rate is partly due to the greater frequency of premium payment. Each time a premium falls due, the policyholder is faced with the question, to pay or not to pay. Whether to yield to the temptation to use the money for present needs or to continue the insurance in force for the protection of himself and his family has to be decided.¹⁴ In the case of the ordinary policy, he faces that decision once, twice, four, and sometimes twelve times a year. In the case of the weekly-premium policy, he faces it fifty-two times a year. Obviously, the more times he is faced with the decision, the greater is the chance that the demon temptation will win over noble intentions.

A factor that is probably even more important is the type of people who

¹² Malvin Davis, *Industrial Life Insurance*, New York, McGraw-Hill Book Co., 1944, p. 138.

¹³ H. A. Lachner, *op cit.*, p. 52.

¹⁴ According to one great life insurance enthusiast, this question involves a serious moral principle. Speaking at the 1914 meeting of the National Association of Life Underwriters in Cincinnati, Professor S. S. Huebner is reported to have said that the proper education in life insurance would lead one to believe that a person has committed a crime if he dies without life insurance. Of the poor departed one, it should be said: "He did not die, he absconded." Cf. R. Carlyle Buley, *A Study in the History of Life Insurance*, New York, Appleton-Century-Crofts, Inc., 1953, p. 442.

purchase industrial. Unexpected expenses or the temporary loss of income to which the hourly wage workers are subject seem to affect the industrial policyholder's ability and decision to keep up his policy more than they affect the ordinary policyholder.

Two other factors account for the higher lapse ratio among industrial policyholders:

Improper Selling. If a policyholder is not properly sold in the beginning, he is always a potential "lapper." Industrial insurance has undergone serious criticism for high-pressure selling. A person who is pressured into buying something he cannot afford, for a need he does not understand, is a likely prospect for lapsation. Some of the high-pressure selling used by agents is caused by the pressure these agents are under from their managers to meet high quotas. Spokesmen for industrial insurance argue that cases of high-pressure selling are the exception rather than the rule. Be that as it may, high-pressure selling can cause lapsation, and lapsation is expensive—especially if it occurs during the early months of the policy.

Improper Servicing. Poor service arises out of the lack of adequate training facilities for agents and from the high rate of turnover among agents.¹⁵ Many companies, however, are making an effort to select and train their agents scientifically in order to improve the service available to policyholders. Some have revised their agents' compensation systems in order to give more compensation for business which continues in force. The result has been to reduce the over-all lapse rate of industrial insurance, since the agent gains by concentrating on quality business.

Because of these inherent lapsation factors, the lapse rate of industrial has been greater than that for ordinary. For instance, Lachner reports that in the Metropolitan Life, one of the largest industrial carriers, the lapse rate for weekly premium industrial in a recent year was one-third higher than the lapse rate for ordinary.¹⁶ His figures were as follows:

Comparative Lapse Rates¹⁷

<i>Weekly Premium</i>	<i>Monthly Premium Industrial</i>	<i>Monthly Debit Ordinary</i>	<i>Ordinary</i>
3.36%	3.08%	2.72%	2.52%

Lachner reports substantial reductions in the lapsation of industrial policies within six months after issue—from 30 per cent in the mid-thirties, to under 8 per cent at present.

¹⁵ The better industrial writers will resent this statement. They will point out—and correctly—that their selection, training, and supervision plans are more careful than those of most ordinary companies and that a high percentage of their agents hold the CLU designation, generally considered to be a mark of the professionally trained underwriter. It is probable that while the major portion of industrial is written by agents of companies with well-trained field forces, these companies do not have the majority of agents by number.

¹⁶ Lachner, *op. cit.*, p. 51.

¹⁷ These ratios express the relationship between the number of policies lapsed or surrendered less reinstatements to the mean number of policies of that class in force during the year.

5. INTERMEDIATE INSURANCE.

"Intermediate," like "industrial," means different things in different companies. At their origin in about 1890, intermediate policies were those issued in amounts of \$500 or more with provision for quarterly or more frequent premium payments. In general (but not invariably), intermediate insurance was composed of policies of between \$500 and \$1,000, written on an annual, semi-annual, quarterly, and sometimes monthly-premium basis, with door-to-door collection.¹⁸

The term, "intermediate insurance," is no longer useful terminology because "industrial" has been expanded to include policies written up to but not including \$1,000 face amount. In addition, some companies issue ordinary insurance for face amounts as low as \$500, if the premium is paid quarterly or monthly. Policyholders applying for more than \$499 of industrial are encouraged to take monthly-premium "debit ordinary." Thus the amounts formerly written under what were called intermediate policies (\$500 to \$1,000) are now written on industrial or ordinary forms.

6. APPRAISAL OF INDUSTRIAL INSURANCE.

Industrial insurance, admittedly expensive and viciously criticized at times in the past, nevertheless contributes to society. Some of the larger writers of industrial insurance have been active in health, sanitation, and safety education. Their activity in this field is based on the assumption that the average industrial buyer is difficult to reach through usual educational channels. The industrial agent, therefore, serves as a medium through which health information is distributed to industrial policyholders.

Through industrial insurance, thousands of working people have received at least some small amount of money upon the death of a member of the family, to pay the cost of burial. Others have received cash from maturing endowments, and still others have drawn on cash values to help out during times of emergencies. For many industrial policyholders, life insurance represents their only form of savings.

No critic of industrial insurance has ever been able to suggest any better private enterprise alternative. Commissioner Sumner T. Pike, of the Securities and Exchange Commission, one of the most bitter critics of industrial insurance before the Temporary National Economic Committee (1938-1940), could think of no alternative other than federal grants for last illness and burial, or the sale of life insurance through the post office.

Post office selling was tried in England and failed. It was tried in Japan and met with a reasonable degree of success. There is, however, no way of

¹⁸ In some companies the term "intermediate" is applied to policies of \$1,000 or more issued to persons ineligible for standard rates. The more common name for such policies is "substandard"; although "intermediate" may be less insulting to the policyholder. "Intermediate" has so many differing meanings that the term alone connotes little until details are given.

comparing the success of post office selling of small amounts of life insurance in Japan with what might have been accomplished there using the methods such as those employed by industrial insurers in the United States.¹⁹ Reference to the experience of the savings banks in Massachusetts, Connecticut, and New York and to the Wisconsin State Life Fund indicates that low-rate insurance sold by post offices in this country might not meet with any particular degree of success.²⁰ Moreover, it would be naive to assume that the quality of selling through the post office would be any better than (or indeed as good as) that of industrial agents. Buyers themselves, unfortunately, cannot be expected to have enough knowledge to decide for themselves what to buy.

As for federal grants for last illness and burial, the question resolves itself into one of political philosophy and is outside the scope of this text.

The proportion of industrial insurance to total insurance has been dropping in recent years. Until 1958, the drop was a result of faster increases of other branches rather than a lack of growth of industrial. Actually, until 1958, industrial had shown growth, about 35 per cent more being in force today than at the end of World War II. It would have shown even more growth had not the three largest industrial companies begun within recent years to issue monthly-premium ordinary in amounts of less than \$1,000. At least one large industrial company is even issuing weekly-premium ordinary.

The rate of growth of industrial has been slower than that of total insurance in force for several reasons in addition to the change in the reporting system of the three companies mentioned:

(1) Since World War II, all incomes have risen, but the lower-income levels have risen even more markedly. Millions who, before the war, would have purchased industrial have moved into income brackets justifying the purchase of ordinary. Moreover, in view of high prices, the amounts of coverage offered by industrial seem even more inadequate to buyers. People who formerly purchased industrial policies of \$500 to \$600 can now buy ordinary policies of \$1,000.

(2) Social Security has cut into the market for industrial insurance. Even for the purpose of providing a burial fund, the motivation in the past for the purchase of much industrial, Social Security offers lump sum death payments equal to or greater than many of the industrial policies purchased for that purpose. In order to compete with Social Security, the combination agent has had to talk in terms of the larger amounts of insurance available through ordinary, thus contributing to the rate of growth of ordinary at the expense of industrial.²¹

(3) The amazing spread of group life insurance since the end of World War II has had its effect on the field of industrial. It is in the highly industrial-

¹⁹ It must not be assumed, however, that the quantity of industrial insurance sold is a measure of the quality of its selling.

²⁰ Cf. Chapter 24.

²¹ A development not without favorable social benefit

ized areas that industrial has lagged most. For instance, compared with the population, very little industrial insurance is written in New York City. Millions of hourly wage and lower-salaried workers who would, in the past, have had no coverage without industrial insurance are now covered by group at their places of employment at either no cost or a very small cost to themselves. Some group plans even cover dependents. Once again, to compete with group, the combination agent must talk in terms of the larger amounts of ordinary.

(4) The family policy has cut into the market for industrial insurance, especially on the lives of children. It has even attracted existing industrial policyholders, causing them to drop their industrial coverage and to replace it with the family policy.

How much these factors will affect the growth of industrial in the future remains to be seen. Some states now prohibit the writing of group on dependents.²² If all such restrictions were removed, it seems inevitable that the effect on industrial would be drastic. The continued expansion of Social Security, which also seems inevitable,²³ cannot fail to have an adverse effect on the growth of industrial. It is common to point out that, since the inception of industrial, there has been a substantial increase in this form of insurance and that, therefore, Social Security has not seriously affected it. In view of the great increases in national income and population, it is a matter of speculation how much greater the rate of increase would have been had there been no Social Security. In the past several years, increases in industrial have not kept pace with the growth of the economy.

However, it seems unlikely that the place that industrial fills will ever be superseded by other forms of insurance, either private or social. There will always be people who, for one reason or another, need to buy "in smaller packages."

A Word to the Buyer. Before leaving industrial insurance, an important point should be made in the interest of the buyer. If one can afford the premiums for ordinary and does not need the budget compulsion of the weekly premium plan, then he should buy ordinary. For example, a weekly premium of 30 cents at age 25 will purchase a \$500 endowment at age 65 from one prominent non-par industrial writer. These premiums amount to \$15.60 a year. For less than \$1.00 a year more (\$16.56), \$1,000 non-par continuous-premium whole life can be purchased from an ordinary writer. The \$1,000 ordinary will have a cash value of \$597 at age 65. Thus 96 cents a year more

²² To some extent, these restrictions have been fostered or maintained by agents' organizations. They see in group, a threat to the agency system, which system, they contend (with some good arguments on their side), has been responsible for the high degree of development of insurance protection in North America and is essential to the continued growth of insurance in force.

²³ "Inevitable" since both major political parties seem to favor it or to "adopt" it, at least as a vote-getting or vote-saving device. Actually, a national election and a new Social Security bill are Siamese twins.

in premiums spent on ordinary rather than on industrial will buy \$500 additional death protection to age 65, and will build \$97 more cash value at age 65.²⁴

7. SUMMARY AND CONCLUSIONS.

While a precise definition of industrial insurance is difficult because it is applied to different types of policies by different companies, in general it is insurance issued in small amounts, usually less than \$500, with premiums collected at frequent intervals, most commonly weekly, by an agent calling at the door.

In general, the industrial branch of the business offers about the same choice of policy forms as found in the ordinary branch, although there are probably not quite so many different industrial forms as there are ordinary. Term insurance in particular is not offered except perhaps as a part of policy combinations involving whole life or endowment.

Most of the provisions of the industrial policy are similar to, if not identical with, those in the ordinary form. However, a number of differences are found. Some of the more noticeable differences frequently (but not always) encountered are these: lack of loan values, settlement options and dividend options, fewer nonforfeiture provisions, earlier incontestability and more restricted grounds for contest, no suicide waiver, more liberal reinstatement provisions, death by accidental means, and dismemberment benefits written as part of the policy rather than as a rider as in ordinary

Some underwriting differences are also noticeable in industrial medical examinations of applicants are unusual. A wider range of physical and occupational condition is considered "standard." The application is not made a part of the policy. Insuring age is *next* birthday.

The cost of industrial insurance is higher than that of ordinary, but not as much higher as some critics have implied. This higher cost is a result of higher industrial mortality, higher lapse rate, and higher administration cost. Industrial mortality runs about 14 per cent higher at all ages combined than ordinary mortality. The difference is greater, however, at younger ages. The lapse rate is higher, but, again, not so much so as often implied, and experience is improving. For instance, one large company reports that, in a recent year, its over-all weekly-premium lapse rate was 3.36 per cent as compared to 2.52 per cent for ordinary. The lapse rate in the first six months has been greatly improved since the mid-1930's, when it ran at 30 per cent. Today it is slightly under 8 per cent. Administration cost is the most significant of the three factors accounting for the higher cost of industrial. A study by one company showed that 90 per cent of the excess in cost of industrial over ordinary is a result of the necessity of collecting premiums in small amounts, at frequent intervals, at the door.

²⁴ This is simply one comparison. Comparisons made between other companies, other ages, or other policies will yield somewhat similar results.

In addition to spreading the benefits of insurance to millions of people who would never buy ordinary, industrial companies have contributed much to health, safety, and welfare activities. They have engaged extensively in health and safety education through distribution of pamphlets and leaflets to policyholders and schools.

The comparative role of industrial among the three branches of insurance is declining, but its continued existence seems assured.

QUESTIONS FOR CLASS DISCUSSION

1. Explain why the term "industrial" is a misnomer for the type of insurance it designates.
2. Among industrial policyholders are many people who could afford ordinary insurance. Does this necessarily mean that industrial insurance is improperly sold?
3. How do you account for the fact that industrial insurance is not written on a term basis? Is this good or bad?
4. In some ways industrial policies are more liberal than ordinary policies and in other ways they are less liberal. How do you account for the fact that these two classes of insurance policies are not identical in their contractual provisions?
5. What provisions would you expect to find in an industrial policy that would not be found in the ordinary policy? How do you explain the differences?
6. Why do you suppose that the sale of industrial insurance has not kept pace with the average rate of growth of life insurance in force in this country?
7. The New York Life Insurance Company is one of the largest life insurance companies in the world. Why do you suppose it does not write industrial insurance?
8. Explain how the job of an industrial agent differs from that of an ordinary agent? Which job would you prefer? Why?
9. Industrial insurance often is severely criticized. Some critics feel it should be outlawed. Can you build a defense for industrial insurance? If so, what would this defense be? If not, why not?
10. What do you suspect the critics of industrial insurance would say in rebuttal to each of the points you made in defense of it in Question 9? Do you have answers for the rebuttal? If you made no defense for industrial insurance in Question 9, what do you suspect the advocates of industrial insurance would say in rebuttal to your reasons for not defending it? Do you have an answer for the rebuttal?

CHAPTER 13

Group Life and Health Insurance

The third class of insurance is group. It is newer, lower-premium, growing faster, and undergoing more changes than either ordinary or industrial. The first standard definition of group insurance was developed by the National Association of Insurance Commissioners in 1917. This definition with its subsequent amendments serves as a basis for state regulation of group insurance. The original definition was as follows:

Group life insurance is hereby declared to be that form of life insurance covering not less than fifty employees with or without medical examination, written under a policy issued to the employer, the premium on which is to be paid by the employer or by the employer and employees jointly and insuring only all of his employees, or all of any class or classes thereof determined by conditions pertaining to the employment, for amounts of insurance based upon some plan which will preclude individual selection, for the benefit of persons other than the employer; provided, however, that when the premium is to be paid by the employer and employee jointly and the benefits of the policy are offered to all eligible employees, not less than 75 per cent of such employees shall be so insured.

Although this original definition has since been drastically amended in a number of ways to be described later, it is still a good description of the basic and distinguishing features of group life insurance. It also provides a springboard for studying the many important changes in group insurance since it was first developed in this country.

1. HISTORY AND DEVELOPMENT OF GROUP.

The meteoric rise of group insurance in this country is one of the phenomena of the insurance business. The first policy was written in 1911 by the Equitable Life Assurance Society of New York on the lives of about 125 employees of the Pantasote Leather Company. At the beginning of the next year, the Equitable formed a group department, and in July, 1912, it wrote \$5,946,564 on the lives of 2,912 employees of Montgomery Ward and Co., a case so large that it brought group insurance immediately to the attention of the American public.

From that start less than fifty years ago, group life insurance has grown and prospered so that today over \$160,000,000,000 is in force covering the lives of close to 50,000,000 people. Actually, at the present time, over half the

country's working force, exclusive of agriculture, has group life insurance coverage averaging nearly \$4,000 per person. Close to \$1,000,000,000 a year is paid out in benefits under group life policies. Today, group represents over one-third of all life insurance in force in the United States.

Phenomenal as has been the growth of group life insurance, its current growth is not so marked as that of group health insurance.

Several types of group health coverages are available. The oldest is loss of income protection, first introduced in 1910. Today, well over 20,000,000 people have disability income protection under insured group plans. The next form to be introduced was group hospital expense, first written in December, 1929, on 1,500 schoolteachers by the Baylor University Hospital, Dallas. Today over 50,000,000 persons are insured against the expense of hospital care under group policies issued by insurance companies and more are being added in staggering numbers each year. In 1938 the first group surgical expense plan was written. This coverage has proved as popular as group hospital coverage, so that the numbers insured are about the same under both types of plans. Group medical expense insurance was introduced in the 1940's; today over 30,000,000 are covered under group plans insured with insurance companies. Group major medical was introduced in 1950. The popularity of this form is growing rapidly. Today, over 20,000,000 people are covered by insurance companies under group policies.¹

At the close of World War II, the total group health premium in the United States was about \$200,000,000. At the present time, it is more than \$2,500,000,000. Over \$2,000,000,000 a year are currently being paid out in health insurance benefits by insurance companies to participants in group health plans. Based on the trend to date, it is not illogical to assume that within the next quarter of a century, group may become the dominant form of life insurance and even more dominant than at present in health insurance.²

2. NATURE OF GROUP INSURANCE.

As previously stated, the basic nature of group life insurance is summarized in the original definition drawn by the National Association of Insurance Commissioners. Under this definition, group life insurance (1) requires a minimum number of participants, (2) may be written either with or without a medical examination, (3) is written under a master policy, (4) requires someone other than the insured to pay at least part of the premium,

¹ To the above numbers, additions must be made for coverage under Blue Cross, Blue Shield, and Medical Society plans (over 55,000,000) and under a number of independent plans (around 5,000,000).

² Whether the rise in the importance of group insurance is good or bad is subject to violent argument within the industry. The acquaintance of the authors with the business and men associated with it—the adequacy of which acquaintanceship is beyond their subjective ability to judge—leads them to suspect that if the “gloves” of public relations were removed, the “sides” of the argument would be preponderantly the field forces of the business (the agents) worried about major increases vs. the home offices (the companies) viewing the rise as a major accomplishment.

(5) must have eligibility standards for participation and a benefit formula which precludes selection against the insurance company, (6) requires at least 75 per cent participation of those eligible if the plan is contributory, and (7) must not be written for the benefit of the employer.

A new definition was adopted in 1946 under what is called the "NAIC Model Group Life Insurance Bill." This bill with its amendments either has been adopted in whole by the states or used as a model for the group insurance law in force. Some states have no group insurance law, and thus the restrictions discussed below will not apply.

The new definition, except for placing a limit on the amount of insurance that can be written on one life, is more liberal than the old, as will be seen as the discussion develops.

The Current Model Group Life Definition. The statutory definition lays out the rules for issuing group life insurance. Since in some states variations from the model law will exist, statutes must be checked for the exact definition in any given state. These variations, however, will not be extreme. The basic characteristics of the latest model bill are as follows:

Eligible Groups. Eligible groups have been broadened from employees of one employer to include (1) multiple employer groups, i.e., employees of more than one employer when grouped under a trustee. The grouping can be arranged either by a combination of employers in the same industry, as through a trade association, or by one or more labor unions whose members are employed by more than one employer. The policy is issued to the trustee. (2) Members of a labor union are also eligible for group insurance under the model law. A trustee is not needed in this case because the policy may be issued directly to the union. (3) Debtors of a common creditor may be covered by group insurance. The debt may arise out of a loan or out of a purchase. Thus the creditor may be a finance company or a vendor. The policy in these cases is issued to the creditor.

The above groups, including the single employer group, are the only ones provided for under the model bill. One or more additional groups are made eligible under the laws of a number of states. Among these are association groups such as teachers, lawyers, and other professional groups; units of state troopers, the state police, the national guard, and the naval militia; depositors or investors in financial institutions such as credit unions, savings banks, and mutual funds; members of fraternal societies, veterans' organizations, or trade associations; members of agricultural co-operatives; and dependents of employees covered under group life insurance policies. The enabling laws for insurance on these groups specify that the group shall have been formed prior to seeking the coverage and shall have a legitimate purpose other than that of obtaining insurance.³

The fact that more types of groups are eligible for coverage in some states

³ About 87 per cent of all group life insurance in force is on individual employer groups, 3 per cent on multi-employer groups, 2 per cent on labor union groups, 5 per cent on employer and labor union groups, and 3 per cent on association groups.

than in others reflects, to some extent, the varying degrees of strength of life underwriters' (agents') associations in these states. Organized life insurance agents seek to contain group insurance. They see in its expansion a serious threat to their markets. The absence or presence of legislative pressure groups on behalf of potential group buyers also accounts for the variations in eligibility requirements. On the basis of sound underwriting theory, the only restriction that seems necessary is that the group shall have been formed prior to seeking the coverage, and shall have a legitimate purpose other than that of obtaining insurance. And if a medical examination were required, even this restriction would seem unnecessary.

Eligible Group Members. In an employee group, all employees of the employer may be eligible including retired employees. Directors of a corporation, partners in a partnership, or a proprietor in a sole proprietorship are eligible for coverage only if they are *bona fide* employees actively engaged in the conduct of the business. In a creditors' group, all debtors are eligible except that no debtor shall be eligible unless he has an obligation to repay which is binding upon him during his lifetime, at and from the date the insurance becomes effective on his life. All members of the union are eligible for coverage under a policy issued to a labor union.

Although all employees are eligible under the model bill, the employer may establish eligibility standards which will cover only certain classes of employees.⁴ However, any class he decides to cover must be determined by conditions of employment.⁵ For instance, an employer might cover only hourly wage workers, or only salaried workers. A college might cover only the teaching and not the clerical and maintenance staffs. It might further restrict the coverage only to those members of the teaching staff who hold the rank of assistant professor or higher.

It is customary in most plans to require a probationary period of service, say sixty days or three months, as a condition of eligibility. The waiting period avoids the clerical work involved in handling temporary or transient employees. Also part-time employees or seasonal workers usually are excluded.

In creditor groups the creditor may choose to cover only certain debtors, but in setting up an excluded class, he must do so on conditions relating to the debt. For example, he may exclude all secured loans but cover unsecured loans.

The insurer might also set up standards for eligibility. One is the actively-at-work requirement which specifies that the employee must be on the job at the time he becomes eligible for insurance or for increases in his coverage. Also, companies usually require, under a contributory plan, that an employee must make application for insurance within thirty-one days after becoming

⁴ The statutes of some states prohibit establishing classes for group insurance purposes based on race, sex, or age.

⁵ A class based on desire for the coverage rather than on conditions of employment obviously would lead to adverse selection.

eligible, or he will be required to submit evidence of insurability upon application for membership. Other cases in which evidences of insurability will be required are the "in-and-outers." Once out, evidence of insurability is required to get back in if there has been no termination of employment. If there has been a termination of employment, evidence of insurability is required to re-enter the plan only if the terminating employee had converted his policy to ordinary insurance under the conversion privilege to be discussed later.

Payment of the Premium Under the model bill, only in creditors' groups may the person whose life is insured pay the entire premium. The creditor, of course, may if he wishes pay all of the premium or share it with the debtors. Only in multiple employer groups is the person whose life is insured not allowed to contribute specifically to the cost of his insurance; the premium must be paid by the trustee from funds contributed by the employers, by the unions, or by employer and union together. In employer and union groups, the employer or union must pay either all or part of the premium. If the employer or union pays all of the premium, the plan is known as "non-contributory"; if they pay only part of the premium, the plan is known as "contributory," since the insured employee or union member must contribute to the premium funds. A few states restrict employee contributions to a maximum of 60 cents per month per \$1,000 of insurance on standard rated groups.⁶

In contributory plans, each employee contributes a flat amount per \$1,000 regardless of his age. The effect is that a young man will be paying a higher percentage of the cost of his insurance than will an older man. Actually, at ages under about 40, the customary employee's contribution of 60 cents a month per \$1,000 (\$7.20 a year) will more than pay the cost of his insurance.⁷ Beyond about age 40, the cost of insurance is greater than his contribution. There is at least some equity in having the employer pay more of the cost of the insurance for the older employees who, on the average, will have rendered more years of service.

If the employer or union were not required to pay part of the premiums, the plan might not work. The rates necessary for older employees might make the average rate, when spread among the participants on the basis of each \$1,000 of insurance, unattractive for the younger members of the group. These younger members, if insurable, might refuse to join the plan, leaving only the older members and the impaired risks. The rate per \$1,000 would then have to be increased, making it too high for the younger members of the older

⁶ In addition to the 60-cent maximum, New York has an alternate restriction limiting aggregate employee contributions to 75 per cent of the premium paid for the coverage.

⁷ The cost, however, is still less than the amount for which he could buy the same coverage from most companies unless purchased as a term rider to whole life insurance. Even when comparable coverage is available at a lower rate initially, that rate will increase as the employee becomes older, and soon will exceed the \$7.20 annual contribution. At that time, the group policy will become more economical for the employee, but in order to get the coverage, he must prove insurability, something he cannot be certain of doing.

group so they, too, would drop out. A further increase in the rate would be necessary with similar results. But if the employer or union pays part of the premium, then the contribution rate can be kept attractive for nearly all employees.

In creditors' groups the debtors can be required to bear the whole cost of the insurance. Under such an arrangement, however, the younger debtors could be victims of unfair discrimination.⁸ They do not reject the insurance, however, either because they are ignorant of the high cost or because of high-pressure salesmanship or other tactics of the creditor. Under some plans even the older debtors may be overcharged. This is accomplished by a process known as *reverse competition*. The creditor persuades the insurer to quote rates higher than necessary and then later refund the excess to him as a dividend. The creditor pockets this dividend as his "cut" on the transaction. Even where the creditor bears part of the premium, the dividend may more than offset his contribution. Regulations have been promulgated in some states, including New York, to control the abuses of group credit insurance.

Size of the Group. The original definition of group insurance fixed the minimum size of employee groups at fifty, but this number has been reduced to ten in the current definition.⁹ Labor union groups must cover at least twenty-five at date of issue; multi-employer or trusted groups must cover at least 100, and not less than five per employer unit. If the plan is established by an employers' association, at least 600 persons must be covered at date of issue unless 60 per cent of the employers, whose employees do not already have group life insurance, participate. In creditors' groups at least 100 new entrants must be expected yearly.¹⁰

The underwriting rules of some companies will not permit them to accept groups as small as the law allows without special safeguards.¹¹ At one time companies wrote small groups at rates in excess of standard, but as competition for "baby groups" developed, rates gravitated back to standard levels. In creditor groups, companies may insist on a volume standard as well as the "100-new-insureds-every-year" requirement. The usual underwriting rule is that there be a minimum of \$50,000 of insured loans outstanding each year. In multi-employer cases, in addition to the 100 lives, some companies require that the case produce an annual premium of not less than \$25,000. These

⁸ In New York the *minimum* rate for group creditors' insurance is 75 cents a month per \$1,000 if the average amount of insurance is less than \$250,000. If the average amount of insurance exceeds \$500,000, the minimum is 60 cents. The rate could go higher if the underwriting conditions of the risk dictate this.

⁹ Some states cling to twenty-five as the minimum.

¹⁰ Remember that these are the provisions of the model law. In some states the requirements may be stricter; in others they are not so strict.

¹¹ Typical of the safeguards required for "baby groups" are the requiring of evidence of insurability for all employees or for those scheduled for the higher amounts, limiting the amount that can be written on any one life; requiring a higher percentage of participation than normal on contributory plans, requiring either that the plan be non-contributory or that the employee's contribution be less than 50 per cent; and demanding more information about the group members and weighing it more carefully before approving the case.

are just a few examples to show that company underwriting rules sometimes are more stringent than the law requires

Two factors account for the requirement of a minimum number of lives: selection and cost

SELECTION. The larger the group the less is the likelihood that the insurance will be taken solely to cover some eligible employee who otherwise would be uninsurable. An employer, for example, might not be willing to cover twenty-four other persons just to insure a twenty-fifth employee who has heart trouble. Even if he would, the larger group makes it possible for the impaired risk to be offset by the other risks, some of which are likely to be better than average. While a minimum of fifty or even twenty-five can be useful in reducing adverse selection, it is doubtful that a minimum of ten is truly effective.

COST. An advantage of group over ordinary insurance is its lower cost. The principal reason for its lower cost is lower expenses; for instance, the employer assumes certain clerical functions. Another of the reasons for lower expenses is the ability to spread certain fixed costs over a large volume of insurance. Unless the group is large enough to yield a high enough premium volume, this cost advantage would disappear. For a reason unknown to the authors of this text (and to the authors of any other work on group insurance), ten lives have been chosen as the smallest possible number of lives that can be covered and still retain a noticeable cost advantage.

Percentage of Group. The model bill requires that in noncontributory plans, 100 per cent of those eligible must be covered, whereas in a contributory plan at least 75 per cent of the then eligible employees must subscribe to the plan.¹² These rules apply in all but the multi-employer trustee groups where all eligible persons must be covered, but this actually is no exception since covered employees are not allowed to contribute under these plans.

This is the one provision of the model law that all states with group insurance statutes have adopted. Even in those states which have no group law, insurance companies insist on the 100 per cent and 75 per cent rules to reduce adverse selection and to hold down expenses. Of course, 100 per cent participation is desirable even in contributory groups to eliminate adverse selection and further to thin down the unit cost, but the lawmakers and the insurance underwriters recognize the near impossibility of enrolling 100 per cent of those eligible. Some will refuse to join because they are not convinced of the value of the insurance; some will refuse to join on religious grounds; and others just procrastinate because of the lack of sufficient motivation. The 75 per cent participation rule allows a practical margin to take care of the "non-believers."

Amount of Insurance. The model law has two provisions dealing with amounts of insurance: benefit formulas and benefit maximums.

BENEFIT FORMULAS. In creditors' groups the amount of insurance on the

¹² Where evidence of insurability is required, the rules allow for the exclusion of those who fail to meet the standard before the percentages are applied.

life of any debtor shall never exceed the amount owed. In amortized debts this means that the insurance on each debtor decreases as each installment is paid. Where the debt is not amortized, but is to be repaid in one sum, the term of the insurance is limited to eighteen months with right of extension for six additional months in case the loan is renewed or defaulted.

In employer, union, and trustee groups, the law requires that the amounts of insurance under the policy must be based upon some plan precluding individual selection either by the employee, employer, union member, or union. Therefore, the amount of coverage for each individual must be established by a predetermined rule called a formula or schedule and not by his own choice. This is, of course, to eliminate adverse selection.

Five methods of determining the amount of insurance on the lives of individual participants are in general use:

- (1) A flat amount for everyone, such as \$2,000 for each covered employee.
- (2) The employee's salary or salary bracket, either an amount equal to, say, one year's salary or \$2,000 for employees earning under \$4,000 a year, \$3,000 for those earning \$4,000 to \$6,000, etc. The wage brackets and amount of coverage for each are, of course, established by the employer or union.
- (3) Based on the employee's job classification; for instance, \$2,000 for employees with no supervisory capacity; \$5,000 for department heads, \$10,000 for officers, etc.—again, the classifications used and amounts for each being the choice of the employer.
- (4) Length of service; for example, \$2,500 for employees with less than five years' service; \$5,000 for those with from five to ten, etc. This method is seldom used today.
- (5) A combination of any of the above methods; for instance, \$1,000 for nonsupervisory employees with less than five years of service, increasing to \$2,000 at the end of five years; \$2,000 for department heads with less than five years of service, increasing to \$4,000 after five years, etc.

Use of the employee's salary or salary brackets to determine the amount of insurance is the most common method, although in a number of trustee plans or plans established through collective bargaining, a flat amount per employee is used.

BENEFIT MAXIMA. The maximum placed on the amount of insurance in creditors' groups is set in the model bill at \$10,000 on any one life. In some states the limit is fixed at \$5,000. Companies, however, set their own limit based on the total outstanding indebtedness to be insured. The larger the total amount of outstanding indebtedness, the higher will be the maximum the company will place on any one life. For example, if the amount of outstanding indebtedness is between \$250,000 and \$400,000, the maximum might be fixed at \$3,000. If the outstanding obligations are between \$700,000 and \$850,000, the maximum on any one debtor might be set at \$7,500. Each company will develop its own schedule. The reason for requiring that the maxi-

must bear some relationship to the total outstanding debt is to assure a practical spread of risks in order to achieve a uniform claim experience.

The maximum limit on any one life in all other groups is fixed in the model bill at \$20,000 unless the employee earns in excess of \$13,333.33 a year. For employees earning over this amount, the limit is 150 per cent of his compensation but in no event more than \$40,000. These restrictions apply only to group term insurance.¹³

Just as in creditors' groups, company underwriting rules limit the amount of insurance that can be written on one life in employer, union, and trustee groups. The maximum written on one life usually bears a relationship to the total amount of insurance in force on the group. For example, the single life limit might be \$5,000 if the total insurance on the group is \$400,000. If more is in force, the single life limit will be higher; if less, the limit will be lower. Each company has its own schedule of maxima, and many companies consider other factors in addition to insurance in force. Among these are whether the plan is contributory or noncontributory, the extent of the employers' contribution in contributory plans, number of employees covered, and the benefit schedule down the line. One purpose of restricting maxima is to guard against adverse selection. Therefore, if an employer develops a benefit schedule under which amounts of insurance for certain employees exceed the insurer's single life limit for the case, the amounts in excess of the limit will be granted only if the employees involved can provide evidence of insurability. Another purpose of the limit may be to reduce the chance of wide fluctuations in mortality experience. If this is the case, the above employer usually can retain his benefit schedule by allowing the group to be charged either for the cost of reinsuring the excess amounts or for building a special reserve to average out fluctuations in mortality experience.

Model Group Health Definitions. Two model group health insurance definitions have been prepared: one in 1940 by the National Association of Insurance Commissioners, and the other in 1948 (with later amendments) by the old Health and Accident Underwriters Conference, drafted for the

¹³ About one-half of the states have adopted the \$20,000/\$40,000 limits. At least a third of the states place no limit on the maximum. The remaining states have limitations which vary from that fixed in the model bill. The plan of limiting the amount of group on any one life is supported primarily by the life underwriters' associations, which seek to limit the amount of group life written in order to leave some of the life insurance market for the individual agent. They argue that the writing of group life insurance in amounts that attempt to make group term a substitute for an individually prescribed and tailored, permanent life insurance program is not in the public interest. They claim that if group should crowd the individual agent out of the picture, or even seriously reduce his ranks, the service of private insurance would be cut off or restricted to the extent that, except on ideological grounds, private insurance would offer no advantages over social insurance. For the purposes of the discussion here, the authors do not seek to analyze the arguments pro and con. Other reasons for the maximum limitations are that the underwriters in insurance offices feel that limits are necessary to prevent this non-medical insurance for executives from being a principal reason for buying group policies, and the concern that benefit schedules of very high limits might bring about a removal of some tax exemptions by the Internal Revenue Service.

National Association of Insurance Commissioners. Neither model has been adopted in its entirety by the states, but both have had at least some influence on the two-thirds of the states that have group health insurance laws. The current edition (1957) of the Conference (now Health Insurance Association) bill is less strict than the NAIC bill in that it requires no minimum number of lives in a group and fixes no specification for minimum participation. The NAIC bill requires a minimum of twenty-five lives and 75 per cent group participation. As to these differences, among the states having laws, four still require twenty-five members, whereas seven require no minimum.¹⁴ The elimination of the participation percentage requirement was not so readily accepted, since seventeen of the states with laws require a minimum participation.

In general, group health insurance is more liberally defined in the statutes than group life insurance. More types of groups are eligible. The Conference bill states that group health insurance may be issued to any group that is eligible for group life insurance. Furthermore, the bill states that group health may be written for any other substantially similar group which, in the discretion of the commissioner, may qualify for such coverage. The only restriction seems to be that the group must have been organized and maintained in good faith for purposes other than that of obtaining insurance. The Conference (Health Association) bill allows for dependents' coverage, something not allowed in the model group life insurance bill but allowed in the group life insurance statutes of some states. In group health, covered group members may pay the entire premium, there being no requirement as in group life that the premium be paid in part by the employer or union. Finally, no statutory maxima are established, leaving this underwriting decision entirely to the companies.¹⁵

Insurance companies are free to establish their own underwriting rules as long as they are not in conflict with state law. In states having no minimum group requirement or no minimum participation requirement, the insurer might well set a minimum limit of five, ten, or even more; and it might require 75 per cent participation where the plan is financed in whole or in part by the employees, and 100 per cent participation when financed in whole by the employer. The insurer may not wish to accept certain types of groups even though these groups are eligible under the law. While the law sets no maximum on benefit levels, the insurer will do so to avoid malingering.

¹⁴ Currently, one state requires fifteen, five states require five, and fifteen require ten members.

¹⁵ Group health insurance may be written without employer contribution because rates do not vary so widely among ages. If this statement is not clear, refer back to the discussion of the reason for requiring employer contributions for group life. Further, inasmuch as group plans currently return about 90 per cent of premium and individual plans return only around 55 per cent, it is possible to write "member pay all" plans at lower premiums than individual policies. Again, it must be held in mind that part of the lower cost is illusory: the employer is assuming certain, rather heavy clerical costs in handling collections, what amounts to policy issue, and even claim settlement.

3. THE GROUP LIFE POLICY.

For convenience of discussion, the holder of the master contract in the group case is referred to here as the "employer" and the participating individuals as "employees." The insurer is referred to as the company. However, wherever the term "employer" is used, the terms "trustee," "creditor," or "association" could be substituted; and wherever the term "employee" is used, the terms "union members," "debtors," or "association members" could be substituted.

Only one policy contract is issued in the group case: the master contract issued to the employer. The individuals whose lives are insured are not policyholders; they are participants in the plan. The evidence of insurance given them is not an insurance policy but a "certificate of participation," or, as most group men prefer to call it, "certificate of insurance."

Standard Provisions in Group Life Insurance. The model group bill sets up a number of provisions which must be included in substance in the group life insurance master policy. Of course, provisions more liberal to the insured or policyholder will be allowed. State laws vary as to standard provisions required, although most states having a group insurance code have accepted the standard provisions prescribed by the model bill. Where a group policy covers insured persons in several states, the statutes of the state in which the policy is issued usually govern. The model group law of the National Association of Insurance Commissioners makes mandatory the following provisions in group policies:

(1) A grace period of thirty-one days during which the death benefit coverage shall continue in force, unless the policyholder shall have given the insurer prior written notice of discontinuance. The policyholder may be held liable for the payment of a pro rata premium for the time the policy was in force during the grace period.

(2) Incontestability after two years both as to the policyholder and the person whose life is insured. As for the latter, this provision is important only when evidence of insurability is required.

(3) Applications, if any, shall be attached to the policy and statements made by the policyholder and participants shall be representations.

(4) A provision stating the conditions, if any, under which the company may require evidence of insurability of any person eligible for coverage.

(5) A statement of how misstatement of age is to be adjusted. Unlike ordinary insurance, the premium usually will be adjusted to the full protection accorded the employee by the benefit formula in use. This seems to be a more equitable arrangement than adjusting the insurance to the premium as in the case of ordinary insurance, because employees are entitled to the full amount of insurance arranged for them under the group formula. The cost of insurance to the employee under a contributory group plan does not vary with his age. However, when the benefit schedule is related to age, the policy usually provides for an adjustment of the benefit.

(6) Facility-of-payment clause in event there is no living named beneficiary for part or all of the proceeds. This clause allows the company to pay up to \$500 of the proceeds to any person who appears equitably entitled to such payment by reason of having paid the expenses of final illness or burial on behalf of the insured.

(7) Certificates of participation shall be issued to each employee covered, stating insurance benefits, the beneficiary, and the rights and conditions of the insured in case of termination of employment or of the group contract. These rights are:

(a) If employment is terminated, the insured may elect within thirty-one days and without medical examination to take an individual policy on any plan but term for the same amount for which he was covered under the group contract at the premium applying at his attained age. This provision does not apply to disability benefits.

(b) If the master policy is terminated, an employee who has been covered for at least five years may take an individual policy on any plan except term for an amount not exceeding the smaller of *either* the amount terminated less the amount of any new or reinstated group coverage effected within thirty-one days *or* \$2,000.

(c) In case the insured dies after termination of employment or of the master contract but within the period during which he had the right to take an individual policy, he shall be covered under the group policy even though no application for the individual policy had yet been made.

Naturally, the provisions discussed in (6) and (7) above do not apply to creditors' groups. A standard provision designed specifically for creditors' groups is the requirement that the insured debtor be furnished a statement that his life is insured and that any death benefit paid will be applied to reduce or retire the debt. A final standard provision requires that if the plan is written on a basis other than term it must contain equitable nonforfeiture provisions.

Other Group Life Policy Provisions. The following provisions, in addition to the standard provisions, usually are found in group life contracts. It will be noted that group life insurance contracts do not contain the suicide exclusion.

Temporary Suspension of Employment. The policy usually provides that in the case of sickness or temporary layoff, the insurance may be continued for a period of several months. A request for an extension of this period usually will be granted to the employer if he continues to pay the premium for the employee on leave.

Clerical Errors of Employer. A clerical error on the part of the employer, such as failing to notify the company that an employee has become eligible for coverage, shall not deprive the employee of such coverage.

Disability. Commonly, the group policy provides that if an employee becomes totally disabled prior to age 60 and remains disabled to the time of his death, the amount of insurance on his life at the time of disability will remain in force. This is, in effect, a waiver-of-premium clause. Annual notice of the continuation of the disability is required. If the group is a select group, meeting more stringent underwriting requirements, the contract can be written to

mature if total and permanent disability occurs before age 60. In this case the proceeds of the policy become payable, usually on a five-year installment basis, as a disability claim rather than a death claim.¹⁶ The lifetime waiver-of-premium clause is currently the most popular type of disability benefit.

Installment Settlement of Proceeds. Although most group insurance benefits are paid in a lump sum, the group policy usually permits the employee or his beneficiary to elect an installment settlement of policy proceeds. Nearly all companies provide for the fixed-amount or fixed-installment options. Some companies will make available the other options customarily offered in ordinary policies. The life annuity rates payable under the options generally are not guaranteed in the policy but are the rates payable by the company at the time the option is selected.

Retired Employees. Group policies may provide for the continuation of coverage on retired employees. In such cases the amount of insurance may be reduced. It is customary for the employer to pay the entire cost of post-retirement protection even if the plan is contributory for active employees.

Employees Covered. Employees who become eligible for coverage under a noncontributory plan are covered automatically without any action on their part. Those who become eligible under a contributory plan must make a written request to the employer (in form of an "enrollment" card) within a stated time after becoming eligible—thirty-one days, for instance. If they wish to enroll in the plan after the period expires, they may be required to furnish evidence of insurability at their own expense.

Alterations of Policy. As is typical of all life insurance policies, the group contract declares that no agent shall have the right to alter or amend the policy, to accept premiums in arrears or extend the due date, to waive any required proof of claim or extend the date when such proof is due. No change in the policy is valid unless approved by an officer of the company (and the specific officers authorized to make changes may be specified) and evidenced by an endorsement or amendment signed by the officer.

Beneficiaries. The employee shall have the right to change his beneficiary at any time by filing written notice of the change with the company and having it endorsed on his certificate. Should the employee die before the actual endorsement is made, the change is effective as of the date of notice. The company, however, shall not be held liable if the proceeds have already been paid before the notice was received.

Assignment. The policy provides that employee benefits are not assign-

¹⁶ This latter provision was commonly included in pre-depression policies without extra premium. Policies issued during, roughly, the depression period provided for the payment of the amount covered if death occurred within one year after the termination of employment if the termination was caused by total disability and occurred before age 65. The disability had to be continuous until death, however. In other words, it was a one-year waiver-of-premium clause. Some group contracts are currently outstanding with each type of disability clause: life waiver-of-premium, maturity value, and one-year extended benefit.

able. The employee, however, by changing his beneficiary may accomplish the same result as an assignment. Nothing in the policy prohibits the assignment of the master policy, which might be desirable in case of a merger, for example.

Register of Participants. The policy requires the employer to keep a record or register which at all times shows the names of participating employees, the amount for which each is covered, the date of entry into the plan, and the time and amounts of any increases or decreases in coverage.

Due Date, Computation, and Payment of Premium. (1) Premiums usually may be paid monthly, quarterly, semi-annually, or annually, and the time and frequency of payment may be changed upon the written request of the employer. (2) Premiums are payable in advance. (3) The company will compute an average rate based on age and female content of the group, using the initial schedule of benefits and the employee data supplied by the employer. (4) At any renewal date, or whenever the terms of the policy are changed, the employer or the company may request a recomputation of the rate to reflect any new schedule of benefits or any major change in the age distribution of employees. (5) The initial premium and the premium on any renewal date shall be the average rate per \$1,000 applied to the total amount of insurance in force on all employees, regardless of the age of each participant. (6) Any premium adjustments involving the return of unearned premiums to the employer shall be limited to the twelve-month period immediately preceding the date when evidence is received by the company that such adjustments should be made. Since premiums are paid in advance, a refund is due when the number of employees is reduced.

Policy Dividends and Non-par Adjustments. If the policy is participating, dividends will be paid in cash to the employer or, on his written request, used toward payment of the next premium. If the plan is nonparticipating, provision is made for a retroactive adjustment of the premium if actual experience indicates that one is merited. An employer usually is entitled to an adjustment if the total of claims paid plus a "retention" percentage is less than the premiums collected. The "retention" percentage is based on the amount the company estimates is necessary for administration costs, contingency reserves, insurance costs,¹⁷ and a margin for profit. Should dividends or adjustments exceed the amounts contributed by the employer in a contributory plan, the excess must be used for the benefit of the employees—refunded to them, used to enable them to skip contributions for a period, or applied to buy additional insurance or benefits.

Renewal. When the plan of insurance is one-year term, the policy contains a provision permitting the employer to renew the contract at the end of

¹⁷ The insurance cost is to pay for bad experience in other groups, i.e., to pay some of the claims in other groups when these claims exceed the premiums collected from those groups. There is always the possibility that the claims in any group will exceed premiums collected. Rates must include an insurance charge to offset this contingency. The larger the group, the smaller is the percentage added in the retention limit for the insurance charge.

the policy year and at the end of each subsequent year, contingent upon (1) payment of premiums, (2) 75 per cent participation in contributory cases and 100 per cent in noncontributory cases, and (3) the minimum number required by the policy (or statute) for a group.

The Certificate of Participation. The master policy requires the company to issue to the employer for delivery to each employee an individual certificate stating the insurance to which the employee is entitled and to whom benefits are payable, and summarizing the provisions of the policy affecting the employee.¹⁸

Surrender of the certificate is a condition precedent to the payment of a death claim or to the exercise of any rights under the policy.

The certificate itself certifies that under a group policy, identified by policy number, the employee is entitled to named benefits subject to the provisions of the master policy; and it identifies the beneficiary. It then gives a summary of the policy provisions affecting the employee, such as:

- (1) Authority of agents
- (2) Cessation of insurance
- (3) Conversion privileges
- (4) Disability benefits
- (5) Change of beneficiary and facility of payment
- (6) The benefit formula or schedule
- (7) Settlement options
- (8) Prohibition of assignment

It also usually contains space for endorsement of any change of beneficiary or amendment of the coverage.

4. UNDERWRITING AND RATING GROUP LIFE INSURANCE.

Underwriting. In group insurance the basis of underwriting is the group covered, in contrast to individual insurance where the basis of underwriting is each individual insured. The group underwriter is not interested in any one individual who is participating in the plan, but in whether or not the composition of the group is such that it can be insured.

Group underwriting differs from ordinary underwriting also in placing less emphasis on accepting or rejecting the risk outright and more emphasis on designing a sound plan for the risk. In other words, it is necessary to underwrite the details of the plan of insurance itself, especially in order to obtain an adequate spread of risk and the economies of group operation. The lack of antiselection is not automatic with group insurance but must be consciously provided for in underwriting schedules of insurance, eligibility provisions, and financing.

Since the underwriting unit is the group, the health of any one given in-

¹⁸ The certificate is neither a contract between the employee and the insurance company nor between the employee and his employer.

dividual is of no consequence except as it may affect the "average." Thus, group requires no medical examination of individuals to be covered.¹⁹ Even individuals with impairments or conditions that would require heavy extra rating in an individual plan, or who would be uninsurable under an individual plan, can be included. They will be offset by the extra-healthy individuals who are included under the plan. Group operates on the theory that if the group is selected, there will be no need to select the individuals, and the average of the group experience will approximate or be better than that of a similar number of individually selected risks.

The group covered under the master contract is, as far as the individuals in it are concerned, a random group, since under a noncontributory plan all eligible members are covered; and under a contributory plan, 75 per cent must be covered. This eliminates much of the choice on the part of the individual participant and is the essential aspect in group underwriting. Where persons to be insured are allowed to decide whether or not to take the coverage, as in individual policies, there will be, on the average, a tendency for the poor risks to seek the insurance and the very good risks to reject it. This, as has been explained, is called "antiselection" or "adverse selection." Given an opportunity, the public will select against the company, giving it proportionately more poor risks than good risks. Although this is true to a substantial degree in life insurance, it is even more of a factor in health insurance.

Two additional factors make it possible to include impaired risks in a group plan:

- (1) A group of employees is to a certain extent preselected. Employers hesitate to hire people in poor health. Some even require a medical examination as a condition of employment. The percentage of impaired risks, therefore, is held down.

- (2) There is some tendency for employees whose health deteriorates to drop out of employment and thus out of the group. In the case of group life, although an individual is entitled to take an individual policy without examination, the over-all rate of such "conversions" is small, running at about 10 per cent.

In the case of employer associations and, to a large extent, unions, the same factors indicated above, which tend to reduce the number of impaired risks, also are applicable. They do not apply, however, to creditors and associations.²⁰ In creditor group there may be no element of preselection. However, since creditor group usually covers persons buying on installments for the period over which they are in debt, individual participants are insured for relatively short periods of time so that the lack of preselection apparently is

¹⁹ As the Commissioners' definition states, group *may* require a medical examination. In actual practice it rarely does. Life insurance medical examinations today cost about \$7.50 to \$10.00. Thus, the elimination of the examination in group is a distinct saving and one of the factors reducing the rate for group in comparison to that for ordinary.

²⁰ In some creditors' groups, however, there may be a form of "underwriting" of the debtor by the creditor similar to the underwriting of employees by the employer.

unimportant. The past experience of creditor group seems to bear out this fact. The lack of preselection also seems to be no problem if sound underwriting controls (effective central administrative office, proper design of plan and rates to control antiselection by age, and adequate participation requirements to control antiselection by health) are established.²¹

Determining the Rate. The problems involved in rate-making for group are much the same as for ordinary. The rate will depend on (1) the total amount of life insurance involved, (2) the disability benefits offered, (3) the plan of insurance, (4) the ages of the members of the group, and (5) the type of industry involved.²²

If the plan is contributory, a flat amount per \$1,000 is established as the employees' contribution. New York law sets the maximum at 60 cents per month per \$1,000, and this is the amount usually adopted. It may be less, of course, at the choice of the employer.

The rate quoted is a weighted average reflecting the composition of the group. The average is computed as follows:

(1) The rate at the attained age of each employee is multiplied by the number of \$1,000's for which he will be eligible. This gives the premium for each one

(2) To find the total premium for the group, add the premiums found for each number.

(3) Divide the total premium by the amount of insurance (in thousands) involved in the group. This gives the average rate, which is the rate charged for the policy. It also will be the rate used for adjustments involving new entrants, and terminations regardless of the ages of such entering or terminating employees. It will be used until recalculated in conformity with the provisions of the policy.

It might seem at first glance that an easier way to arrive at the average would be to average all ages involved. This method would give an erroneous result. Actually, it is impossible to average ages for insurance because, as ages increase, the mortality costs increase at a faster pace. The death rate at age 50 is more than twice that at age 25. It would be possible to average ages for group insurance premiums only if the death rates and ages increased at the same pace. Table 21 will clarify the problem.

TABLE 21.

<i>Number of Employees</i>	<i>Age</i>	<i>Death Rate</i>	<i>Total Death Rate</i>
10	25	2.88	28.8
10	35	4.59	45.9
10	45	8.61	86.1
			<hr/> 160.8

Average mortality rate for this group: $160.8 \div 30 = 5.36$

²¹ Perhaps the real question is whether use of individual evidence of insurability is proper for group insurance.

²² In general, rates are determined by the nature of the industry, not by the job classifications of individuals in the group.

In this case, the average age is 35, and the average mortality rate for the group is 5.36. To use the death rate at age 35 (4.59) for rate-making would understate expected mortality experience, for the actual "average" of the death rate for the group (5.36) is a factor falling halfway between the mortality rates at age 37 and 38. Thus, it is erroneous to average the ages of the group for use in premium calculations. It is necessary, instead, to calculate the rate for each age in the group before an average rate can be found.

If the group requires an extra rating (i.e., if it is "substandard"), an amount is added to the total premium which represents the estimated difference between standard and expected mortality for the year (in the case of group term). If only part of the group is subject to the extra hazard (as, for instance, an organization with two plants, only one of which is engaged in extra-hazardous work), the cost of the extra premium is, nevertheless, distributed over the entire group. The average rate is always the same for each member of the group regardless of his age or the job he performs.

The initial rate is usually guaranteed for the first year—sometimes longer.

In adjusting the average rate, the company takes into account its experience with the particular group and with all other groups, the latter factor being one of the elements taken into consideration when the retention percentage is set.

Comparative Cost of Group Life Insurance. Group is the lowest cost form of life insurance principally because of its low expenses of operation:

(1) Group insurance is written without medical examination, eliminating the fee for such examination that must be added to the cost of individual policies. In the case of individual policies, it is almost universal to order an independent inspection (or "credit") report, adding several dollars more to the cost. (Costs of inspection reports vary by locality and also by type of report.) Such reports are ordered even when non-medical insurance is issued and so are an addition to cost even where an examination by a physician is omitted.

(2) In the mass, group requires less sales solicitation per insured. One group case may require more sales solicitation than any given individual case, but the group case will cover a number of lives instead of only one. Thus sales cost is spread over vastly more units. Further, much of the work entailed in a group case solicitation may be absorbed by salaried employees from the home office. Therefore, the actual sales commissions on group are much lower than on individual. Commissions to soliciting agents (as contrasted to salaried "group representatives") are paid on a sliding scale that decreases as the total coverage involved in the group rises.

(3) Much of the service rendered to individual policyholders by the insurance company is rendered, instead, by the employer, thus reducing the insurer's cost of administration.

(4) The insurance company's own administrative expenses are lower because within each group, coverage is standardized for all insured persons.

In spite of the fact that there is usually no medical selection, group mortality experience is no worse than ordinary. In fact, mortality studies indi-

cate a slightly better over-all experience for group, especially when compared to ordinary policies in force in excess of five years.²³

The mortality cost among converted group certificates, however, is higher than among regular ordinary policyholders. Those in bad health are more inclined to convert their policies, while those in good health may not take advantage of the conversion privilege.²⁴ The adverse selection resulting from the conversion privilege is charged against the group contract by assessing a charge of from \$60 to \$75 per thousand of converted insurance.

Table 22 will give some indication of the cost differences in group and ordinary insurance when both are issued on a yearly-renewable term basis.

TABLE 22.

Non-par Yearly-Renewable Term Rate Per \$1,000

<i>Age</i>	<i>Group ^a</i>	<i>Ordinary</i>
20	\$ 4 09	\$ 6 71
30	4.66	6 98
40	6 54	8 79
50	13 57	14.39
60	27 55	30.41

^a These rates are slightly lower than the initial minimum required under New York law.

Note that rates at ages 20, 30, and 40 are less than the \$7.20 required of participants under a contributory plan calling for the maximum of 60 cents a month. Note also that the cost of insurance at 20 and 30 is less even at ordinary rates than the 60-cent monthly contribution. Since the group rate is subject to a retroactive rate reduction based on the experience of the group, these comparative figures understate the cost advantage of group insurance.

The annual cost before dividends or retroactive premium adjustments for group term insurance in the typical case usually runs about 1 per cent of the total amount insured; it is somewhat higher if the group contains a large number of older people or is engaged in hazardous employment, and somewhat less if the group contains a relatively large number of young people or is a better than average risk.

5. GROUP PERMANENT.

While the vast majority of group life insurance policies are written as one-year renewable term, an increasing number of group contracts are written

²³ Actuaries and underwriters figure that the effect of selection wears off in five years. Mortality data for policies in force in excess of five years are called "ultimate" data as distinguished from "select" data for policies in force five years or fewer.

²⁴ Often, even employees who are uninsurable fail to convert their policies. Sometimes the reason is ignorance or lack of interest, at other times it is the inability to pay the premium for permanent insurance. Were it possible to convert to term forms for more than a one-year period, the chances are that a greater percentage of group would be converted.

as "group permanent." Group permanent plans are used where group life insurance is designed to protect against both premature death and old age, or, even more commonly, where the employer wishes to give the employee a paid-up policy at retirement. Two major types of group permanent are written: unit-purchase and level-premium.

The Unit-Purchase Plan. The more popular group permanent plan is the unit-purchase plan known generally as the group paid-up plan. The plan involves a combination of single-premium whole life insurance with decreasing term insurance. Usually the amount of group term purchased on each employee will decrease as the amount of permanent increases, so that the total amount of insurance in force on his life remains constant.²⁵ Customarily, the employers' contributions are used to buy group term, whereas those of the employee are used to purchase units of paid-up group permanent. Since the employees' contributions remain constant, the additional amount of paid-up permanent purchased decreases each year because the rate goes up as the employee's age advances.

For example, assume that the employee under the benefit formula is entitled to group insurance equal to his annual salary of \$6,000. He is 24 years old when he becomes eligible for coverage. If the employee contribution rate is the customary \$1.30 a month per thousand (it could be more or less), his premium after the first year will buy \$247.08 of paid-up permanent insurance and his employer will pay for \$5,752.92 of one-year term insurance. Next year his contribution will buy \$242.40 of paid-up whole life giving him a total of \$489.48 of paid-up insurance, leaving his employer to purchase \$5,510.52 of one-year term insurance. Assuming no changes either in his contribution rate or the rates for paid-up group permanent, by the time the employee reaches age 65 he will have accumulated \$7,218.72 of paid-up life insurance.²⁶ Of course, the older the employee is when he enters the plan, the less will be his paid-up life insurance at retirement. For example, if he had started at age 40, his paid-up life insurance at age 65 would be only \$2,047.92. For this reason, instead of a flat rate for each employee, some plans call for a contribution rate which varies with the age of the employee at the outset but remains level throughout the period of coverage. Special arrangements involving a continuation of term insurance after retirement sometimes are made for employees who are within twenty years of retirement when the plan is installed, because they will not have had time to build an adequate amount of group permanent.

²⁵ That is, assuming that the employee does not shift from one benefit class to another.

²⁶ A case such as this might lead the employer, at first blush, to consider a lower rate of contribution for employees entering at such young ages, since this employee will have paid-up insurance of \$6,000, the amount of his scheduled benefits by the time he passes age 56. This means that the employer will not be participating in the plan during the last nine years. But since normal progress and cost-of-living increases will almost certainly raise the salary of this young lad to a figure well over \$6,000 a year, long before he passes age 56, chances are excellent that his paid-up insurance will never equal his formula benefits, and his employer will always be participating in the plan.

In the usual case, group term is terminated when the employee resigns, is fired, or retires, but it is, of course, subject to conversion at the attained age. The group permanent remains in force since it is paid-up insurance. Instead of retaining the permanent insurance, however, the ex-employee has the option of taking its cash surrender value. Cash surrender values, however are not allowed while the employee remains under the plan.

The Level-Premium Plan. Under the level-premium plan of group permanent, any policy other than term can be used. Life paid up at age 65, endowment at age 65, retirement income, whole life, and life paid up at 85 are common. In level-premium group permanent the employees' rights upon termination of employment depend upon the nature of the vesting. If the plan is noncontributory and no rights are vested in the employee, then all he has is the right to convert to an individual policy. The employer is refunded the cash value. If the plan is contributory or is a vested noncontributory one, the employee may take the cash value or the paid-up value, or he may continue the entire amount of the coverage in force by paying the full premium direct to the company. If it is a qualified contributory plan, the employee will be entitled to receive at least his deposits and, in some instances, interest on them, which may exceed the cash value.

Whereas the usual purpose of the unit-benefit group permanent is to fund a paid-up life insurance policy for employees at retirement, the usual purpose of level-premium group permanent is to fund income benefits for employees at retirement under a qualified pension plan.²⁷ The nature of the tax treatment of group permanent accounts for the difference in the use of the plans. Where reasonable in amount, employers' contributions to group permanent are a deductible business expense if the plan is qualified as a pension plan under Treasury Department regulations. (If the plan is not qualified but the rights of the employees are currently nonforfeitable, the contributions of the employer will still be deductible as a business expense.)

The income tax consequences to the employees depend on whether or not the plan is qualified as a pension plan. In nonqualified plans where the rights of the individual employee are nonforfeitable, the employee must report as taxable income in the year paid, the full amount of the group permanent premium paid on his behalf by the employer. In qualified plans, the employee reports as taxable income, only that part of the group permanent premium paid by the employer that is used to provide life insurance at a one-year term insurance rate. The remainder is treated as deferred income.

Since premiums on group term insurance need not be reported as income by the employee, the usual procedure in nonqualified plans is to use the unit-purchase (group paid-up) plan under which the employer's contributions are used to buy the group decreasing term insurance, and the employee's contributions are used to buy the group permanent paid up coverage.

²⁷ A qualified pension plan is one that is approved by the Internal Revenue Service for favorable tax treatment. Pension plans are discussed in Chapter 14.

In qualified plans, the situation is somewhat reversed. The level-premium plan of group permanent insurance is used. Under it, the employee's contributions are allocated, first to pay for the insurance protection at one-year term rates, and the employer's contributions are used, first to build the cash values. A simpler solution (and the logical one under a noncontributory plan) would seem to be to provide death benefits through the group term life insurance and to fund the pension benefits through a group annuity contract.

6. WHOLESALE INSURANCE.

Wholesale insurance is an adaptation of some of the principles of group insurance to groups which are too small to qualify for group coverage. Wholesale is used also in some large groups where the required percentage of participation cannot be obtained under a contributory plan.

Under "wholesale," individual policies are issued to each person in the group, and individual underwriting is done. Physical examinations may be required, although in practice they are usually waived in favor of a statement of health. The employer, while not applying for the insurance, signs an agreement with the company to pay the premiums. The plan may be contributory or noncontributory, but in either case the employer is responsible for the payment of the premium, and (if the plan is contributory) for its collection from employees.

Wholesale is sometimes also available on a "guaranteed issue" basis, especially where 100% of eligible employees are covered. In such a case, individual underwriting is eliminated, as in true group insurance.

Wholesale is written under conditions designed to eliminate as much adverse selection as possible. The amount for which the employee is insured is not left up to him but is set by a predetermined schedule.

As in group, the usual plan of insurance is one-year term, and the method of arriving at the rate is the same as in group. The insured names his own beneficiary and has possession and control of the policy (instead of having only a certificate of participation). The contract usually carries the "conversion" privilege. Because of the smaller size of the group covered and consequently a higher administration cost, the premium for wholesale is higher than for group.

Since the number of participants required under group has been reduced, wholesale has found less application than formerly.

7. GROUP HEALTH INSURANCE.

Most of what has been said of the theory of group life insurance also applies to group health insurance. The number of similarities between group health and group life is greater than the number of differences. The differences result principally from the nature of the perils covered and the greater liberality in defining (or not defining) eligible groups.

The Group Health Contract. Just as the group life contract differs in some

ways from the ordinary life policy, so does the group health contract differ in some ways from the individual health policy.

Differences between Group and Individual Contract Provisions. Most group health policies provide benefits only for nonoccupational accidents and illness. Occupational disabilities are left to the coverage provided under workmen's compensation laws. For an extra premium, loss of income from occupational injuries can be covered under group health. Because the income benefits under workmen's compensation often are low, it is considered desirable to include occupational disability income coverage in group plans, especially in those industries where the added cost for this coverage is nominal. Sometimes a supplementary contract providing only for occupational loss of time is written in lower amounts to integrate with workmen's compensation so that the employee receives the same income whether his disability is occupational or nonoccupational. Because workmen's compensation medical benefits generally do not require supplementing, occupational coverage for medical care is rare in group policies. It is not usual to exclude occupational disabilities in individual policies except under certain hazardous occupational classes.

The standard or uniform provisions, required by law to be contained in individual contracts, are not required in group contracts. These provisions are for the most part details relating to the presentation of claims. Provisions in group policies on claim handling usually are more liberal than the standard or uniform provisions, so that the use of these provisions actually would be restrictive. Other provisions similar to those set forth in the standard or uniform provisions which are protective to the policyholder, however, are required in group policies.²⁸

Clauses prorating benefits for other insurance, change of occupation, misstatement of age, and time limit on legal action are examples of other individual policy restrictions omitted in group.

Greater liberality in group provisions is possible because (1) loss-of-time benefits payable are relatively smaller than those under individual policies and are for shorter periods, and (2) the rate under group coverage may be adjusted up or down periodically. The employer, therefore, has an interest in preventing claim abuse and improving his loss experience.

The insuring clause for loss-of-time benefits is more liberal in group than in many individual policies. In group contracts, disability is defined in terms of the employee's *own* occupation rather than in terms of *any* occupation. The

²⁸ In the Health and Accident Underwriters' Conference bill (cf. a previous section in this chapter, "Model Group Health Definitions"), only three standard provisions were proposed: (1) Only statements made in writing should be used to avoid or reduce the insurance and in the absence of fraud, all statements should be deemed representations and not warranties, (2) a certificate of insurance should be delivered to each covered employee setting forth the essential features of the coverage, and (3) new employees and dependents might be added to the group from time to time in accordance with the terms of the policy.

usual definition is the inability to perform any and every duty of the insured's own occupation. However, there is currently a trend toward an even more simple definition, requiring only that the insured employee be unable to perform his regular work.

Some Important Similarities. Several important provisions appear in both group and individual contracts. These include beneficiary provisions in accidental death coverages, notice of loss, proof of loss, and time period for filing suits. In addition, the insurer may reserve the right to refuse renewal of the group policy on any renewal date. The right to refuse a renewal applies only to the master contract. No individual participant may be cancelled or denied renewal *except* by termination of the entire group.

Termination of the master contract or of an individual certificate is without effect on prior disability, just as in the case of terminations of individual policies. Moreover, a period is allowed after termination during which claims developing out of conditions existing at the time of termination are covered. For example, group hospital and surgical benefits usually are payable for three months after termination if the claims are the result of a condition existing when the contract was terminated but which did not require hospitalization or an operation at that time. This extended benefit generally applies only to illnesses causing the insured to be totally disabled at the time his coverage terminates. Pregnancies in progress at termination are covered; and any maternity benefits applicable are paid if incurred within nine months after termination even if pregnancy was not known to be in progress at the time the contract or certificate expired.²⁹

Similar Provisions in Group Health and Group Life. Some important provisions are common to all group insurance. Since these provisions have been explained, they need only to be mentioned here. They include the clauses dealing with dividend or retroactive rate reductions, payment and adjustment of premiums, employer reports, assignment, the grace period, employer omissions, and now more frequently the conversion privilege.

Types of Coverage. Group insurance can cover virtually all insurable health losses in any combination. The following are the most frequent coverages and ranges of benefits:

Disability Income Coverage. Disability income coverage is designed to replace, partially and usually temporarily, any loss of earnings resulting from the inability to work because of illness or accidental injury. Weekly or monthly indemnities are included in event of disability as defined in the policy. Income benefits resulting from accidents may begin with the first day of disability, whereas a short waiting period, seven days being typical, is required for sickness benefits. Benefits usually are payable for thirteen, twenty-six, or fifty-two weeks, except that benefits for disability from pregnancy will be more limited, six weeks for example. The amount of the benefit is scheduled in the policy and usually bears some relationship to salary.

²⁹ This is true in substantially all group health plans covering maternity, but not always in service-incurred forms of group health.

Accidental Death and Dismemberment. Principal sums often are made available for accidental death and dismemberment benefits. Accidental death and dismemberment coverage sometimes is written without loss-of-time benefits, and frequently pays for occupational as well as nonoccupational injuries. In hazardous industries, however, it is usually written for nonoccupational accidents only. When written without loss-of-time benefits, it is usually written as a supplement to group life insurance. The coverage is written in terms of a principal sum with a schedule of benefits such as the principal sum for death or severance of both hands, etc.; and one-half the principal sum for severance of one hand, etc. The coverage is attractive chiefly because it is inexpensive. Like the disability income coverage, it is confined to the employee only and does not extend to dependents. The rest of the coverages to be discussed are available for dependents unless otherwise indicated.

Hospital Expense. Hospital room and board may be covered for a flat per diem up to a maximum number of days, such as thirty-one or seventy; while miscellaneous or "special" hospital expenses are covered, usually on an "unallocated" basis, up to a maximum of fifteen or more times the allowance for daily room and board. It is common to allow a substantially greater limit beyond the fixed multiple of room allowance, but with a co-insurance factor under which the insurer pays three-fourths and the insured pays one-fourth of the amount over a given maximum. The purpose of the growing liberality in hospital extras is to help offset the cost of the "wonder drugs," which is to the benefit of the insurer since, while expensive, they shorten the hospital stay. Maternity benefits up to a maximum of about ten or fifteen times the daily room benefit or up to a flat amount may be allowed.

Surgical Expense. Indemnities for surgical procedures are written, usually as set forth in a schedule of maxima for each procedure, as in individual health insurance policies. Surgical schedules are discussed in Chapter 11.

Medical Expense. Several types of medical expense coverage are usually available: (1) "In-hospital" covers medical attendance other than surgical up to a daily maximum and for an over-all maximum. The customary limit is \$3 or \$4 per day with a maximum of \$150 or \$200 for the duration of the hospital confinement. (2) "Total disability" covers physicians' calls while in the hospital on the same basis as above, or, while outside the hospital, subject to so much per call and maximum limits when totally disabled. Usually some form of deductible is applied for visits outside the hospital. Because of the difficulty of applying the total disability test to others than the employee, this form of medical expense coverage is unavailable for dependents. (3) "Comprehensive medical expense" covers physicians' calls at so much per call and an aggregate number of dollars regardless of the nature of the disability. Usually the first two or three calls are excluded. Maternity calls also are usually excluded, especially after diagnosis. (4) "Diagnostic" covers expenses up to a specified maximum for the cost of X-ray examination and most other laboratory tests or analyses made while the insured is not confined to the hospital. (5) Dental expense covers the cost of dental work.

Major Medical Expense. The purpose of major medical is to pay the large medical losses. It is virtually blanket coverage for expenses between a deductible and an aggregate maximum, often written with a co-insurance feature under which the insured pays 20 per cent or 25 per cent of the covered expenses. Group forms of this coverage are the same, in general, as described in Chapter 11. When written without basic coverage, the deductible is an initial deductible with the employee bearing the cost of his small budgetable medical expenses. When written in combination with a basic plan, the deductible will be either a corridor or an integrated one. A corridor deductible requires the insured to pay the deductible after the basic plan is exhausted before the major medical plan assumes any liability. An integrated deductible allows the basic plan to be applied to the deductible. If the benefits under the basic plan are less than the deductible, the effect is to have a small corridor deductible. If the benefits under the basic plan are larger, then the deductible is assumed to be the basic plan. Major medical is growing increasingly popular in group health insurance programs.

Blanket. Blanket coverage may be considered a separate phase of group insurance. It is similar to group in that it covers a number of people in one policy as contrasted to one individual per policy. It is unlike group in that the individuals covered are not specified and may change constantly.

Blanket coverage may be written on all passengers of a common carrier, for example. Under this form of insurance, anyone aboard the carrier at the time of an accident is covered. It is issued on spectators at a sporting event; to an institution of learning, covering all inmates; to volunteer fire, ambulance, and first-aid groups; to campers at a camp; to members of an athletic team; and, in general, to any association of persons having a common denominator other than the insurance coverage itself.

8. REASONS FOR USING GROUP.

Four reasons for establishing a group insurance plan in any given business are to improve industrial relations, to fulfill social obligations, to meet the demands of unions, and the desire of the employer or key men to obtain their own personal insurance at low rates.

Industrial Relations. Much is made of the industrial relations aspects of group insurance by writers and salesmen. Group plans are said to attract better employees, reduce employee turnover, and improve morale and efficiency; but in the opinion of the authors, the value of group insurance in attracting and holding employees is at least open to question.

First, it may seem logical to argue that the worker will accept whichever job gives him the greater insurance benefits if all other working conditions are between two available jobs are equal. However, particularly in the case of life insurance, anyone who deals with prospective buyers knows there is a lack of logic in the thinking of many people about the need for and ownership of insurance.

Second, the value of any condition of employment depends on contrast. If two jobs offer the same conditions, those conditions are no factor in influencing a person in the choice of or encouraging a person to remain on a job. Today, group insurance is so widespread in business and industry that it offers no contrast. Whichever job he chooses, the employee will usually be covered by group; and almost any other job to which he might shift will be covered also. It is possible that the lack of an attractive group plan might prove a disadvantage in obtaining employees and holding them; but under today's conditions it would appear that the existence of a good plan has little effect in obtaining or holding employees.

There is little question that group improves morale and hence efficiency. In the first place, it may have some effect on morale by giving the employee a feeling that the employer has at least some degree of concern for his welfare off the job. But more important, group will help raise morale and efficiency by reducing the financial worries of employees. The effect of group in this respect is probably less important in life insurance than in health insurance. However illogical it may be, few healthy people worry much about dying or the effect of their death on their dependents—except when forced to do so by the life insurance agent. People are conscious, however, of the costs of accidents, sickness, and hospitalization. The employee may already have experienced the cost of disability. Further, there is constant publicity about the costs of medical and hospital care, which keeps the employee reminded of the potential financial crisis he faces. Group health insurance will lessen his worry about possible loss.

Social Obligation. Throughout the twentieth century there has been a growing philosophy that the employer has an obligation to his employees over and beyond wages. In fact, failure to take such responsibility would today be considered the worst kind of public relations.

Since the employer feels an obligation to "do something" for sick or injured employees or for dependents of deceased employees, he faces a potential monetary loss (expense). This loss is unpredictable both as to time of occurrence and as to amount; therefore, it is a proper subject for insurance. The employer, through group insurance, can protect himself against this potential loss. If he does not insure it, he stands to pay a large, uncertain loss out of pocket. The possibility of this potential loss may be a factor in the employer's decision to install a group plan.

Demands of Unions. In recent years, group insurance has moved into the scope of collective bargaining. Employee financial security is of vital concern to unions. Unions recognize that group insurance is an effective way of providing this security. The direct demand of unions for group insurance has been one of the principal reasons for establishing group insurance plans. Either the union makes a direct demand on the employer to establish a plan, or the employer establishes it in anticipation of union demands. Employers may feel that they have better control over plans established independently of

unions and that they enjoy a greater advantage in employee relations by initiating the plans themselves. The employer, however, cannot establish a plan independently of the union if the union chooses to bargain for it. Group insurance is subject to collective bargaining and the union has a legal right to insist on having a part in the formulation of a group insurance program. Often the union insists upon exercising this right in order to lead its members to feel that the union is gaining advantages for them which they might not otherwise have gained. Sometimes, by the bargaining process, the union does achieve a more favorable plan for its members.

A basic argument in negotiations for group insurance is whether such a benefit is a *part of wages* or a *supplement to wages*. At present, the underlying principle is not clear. Both employers and unions will take one side or the other of the argument, depending on its effect on the negotiations at hand.

"Get It Wholesale." Some group plans are established because the employer in a smaller business or the executives in a larger one look at group insurance as a way to get life insurance at less than the individual policy rate. Even where there is a statutory limit on the amount of group coverage that can be written on an individual life, the limit usually allows a substantial amount of insurance, and the premium saving, therefore, also is substantial. Premiums paid by the employer for group insurance are deductible as a business expense. This further reduces the effective cost of this type of insurance. In a large business, where ownership and management are divorced, executives find it easy to sell themselves on life insurance when the premiums are to be paid out of corporate funds. Stockholders rarely object. The owner-manager in the small business may be just as much intrigued with the tax savings involved and the low cost of group coverage on his own life as he is with the needs of his employees. The appeal of group insurance to executives is especially strong if these executives are otherwise uninsurable.

In summary, it can be said that there are business, social, and selfish reasons for establishing group insurance in any given business or industry; and finally, group coverage has become so widespread today that the business which is without it stands out as an oddity and is likely to suffer in its employee and public relations.

9. AN APPRAISAL OF GROUP INSURANCE.

Although the amount of group insurance in force is influenced by economic conditions, group insurance has become so much a part of the employment picture that even the severest economic depression could have no more than a temporary effect upon it.

Group life insurance has already begun to replace industrial insurance as the form of protection most often owned by lower-income groups. Group also is having an effect on the ordinary life insurance business by taking care of the demand for the smaller policy.

In the life field, both industrial and ordinary were well developed before

group appeared on the scene. In the health insurance field, great strides in individual coverage were not made until the 1950's, when the group plan of writing insurance already was well established and booming. It is possible that, because of the greater efficiency of group, individual health insurance will never develop to the ranking position that individual contracts have achieved and still hold in the life business. People generally need more than their group insurance to complete their life insurance programs; but group health insurance, especially for hospital and medical expenses, is often sufficient without reinforcement. While group life insurance usually supplements individual life insurance, group health insurance frequently supplants individual health insurance. Only in the area of total and permanent disability income protection has group insurance not become a major limiting factor to the growth of individual contracts.

It will be recalled that individual contracts account for nearly two-thirds of the life insurance in force, whereas in group health insurance, individual contracts account for only about one-third of the premiums written.

Group and the Agency System. While group insurance technically is sold under the agency system, it probably would be more practical to describe the marketing of group as a channel which utilizes services of the agency system merely because that system is there and traditional. Group insurance is bought and not sold. Agents may initiate group cases, but details more often are handled by salaried group representatives. Usually there is little agent-client relationship between either employer and agent or employees and agent. In the small or medium-size group case, an enterprising agent might some time take advantage of the opportunity to serve individual employees as a means of developing sales of additional insurance if the need exists; but, by and large, the individual agent plays a minor role.

Occasionally, some companies will write group "around" the agent; i.e., they will write it direct and pay no commissions. This trend was given much impetus in 1954 by the federal employees' case in which \$6,700,000,000 of group life was placed in force on 1,700,000 federal workers with payment of only a token commission. Unions have been bargaining for group written direct without commissions and probably will, in the future, demand that larger cases be so written.³⁰ The New York law, however, requires that a commission be charged against every group case regardless of whether the commission is actually paid.

Some individual agents and the life agents' association are active in fostering or protecting legislation which keeps group life from expanding further into dependents' coverage, high individual limits, and association fields. Many individual agents, however, see no threat; so the agents' ranks are not unanimous in their view of the possible effect of group insurance on their markets. For the

³⁰ The agent can perform a useful function in the marketing of small group cases. Only in the marketing of the large case is there some question as to the necessity of the agent.

most part, companies have no fears at all about the expansion of group into any area that can be underwritten, although they are sometimes restrained in their pronouncements on the subject as a matter of maintaining good relations with their agency forces.

Group and Social Insurance. Some advocates of group contend that group retards the growth of social insurance. They argue, with logic, that the demand for social insurance coverage arises from people who have inadequate private coverage and that the best way to decrease the demand for social insurance is to see that everybody has private insurance. Group, they say, offers the means of spreading private protection to all people.

On the other hand is the argument that one of the advantages private insurance holds over social insurance is the service of the agent. The individual agent services group and existing social insurance such as Social Security, National Service Life Insurance (NSLI), and veterans' benefits. He does this in the course of his work in counseling people on their insurance needs, in programming coverages for them, and in helping settle claims.

Group and Society. Group insurance offers a number of advantages over ordinary insurance. These advantages must not be overlooked in any appraisal of group insurance. One of the principal advantages is its ability to provide low cost insurance protection by using efficient marketing and administrative techniques. It also spreads insurance to a number of people who would otherwise be without it. Among this group are those who are not sufficiently motivated to buy insurance, those who feel that they cannot afford insurance, and (most important) those who are uninsurable for individual contracts. The social importance of group insurance is recognized in the tax laws, which (in general) allow the cost of group as a deductible expense to the employer and do not consider the premium the employer pays as taxable compensation to the employee.

10. BASIC DECISIONS IN ESTABLISHING GROUP PLANS.

In the formation of a group insurance plan, several decisions will have to be made.

Contributory vs. Noncontributory Plans. Should the plan be contributory or noncontributory? The answer to this question will depend on several considerations, namely, administration, cost, control, and employee appreciation.

Administration. The noncontributory plan is simpler to administer. All employees of an eligible class are automatically covered, thus eliminating the task of selling the plan to 75 per cent of those qualifying. Record-keeping is much simpler because the employer does not have to withhold funds from participating employees, record collections, hold the money until premium-due dates, and get waivers from nonparticipating employees. The possibility of troublesome clerical errors is reduced.

Cost. The contributory plan makes it possible for the employer to offer higher limits of coverage without a correspondingly higher premium outlay on

the part of the employer. On the other hand, income tax considerations favor the noncontributory plan. The entire cost of a noncontributory plan is a deductible business expense. Under the contributory plan, employees are not allowed to deduct their contributions in reporting income for tax purposes. The opportunity to pay 100 per cent of the premium with tax-free dollars gives the noncontributory plan a decisive cost advantage to the participating employee. Premiums paid by employers for group insurance need not be reported as income by the participating employees. Thus, the employee receives, in effect, a tax-free increase in income in the amount of the premium.

Control. In general, the employer has more control over the plan when he is financing its full cost. Employees expect to have more influence on a contributory plan. In a negotiated plan, however, extent of control may not be affected by the method of financing the plan. Unions tend to favor noncontributory plans as well as the retention of some measure of control.

Employee Appreciation Some group men argue that the contributory plan makes the employee more conscious of his insurance and consequently the employee-relations value of the plan is more effective. On the other hand, the noncontributory plan, some group men insist, is more acceptable to the employee because he looks upon it as a "gift." Under the contributory plan, the employee tends to think that he is paying for what he gets. He may overlook or discount his employer's contribution. In fact, some employees under a contributory plan do not even understand that the employer is paying any part of the cost.³¹ In favor of a contributory plan is that it provides coverage only for those employees who appreciate the plan enough to enroll in it and pay the premiums. Those who do not enroll will not be participating in the employer's contributions, leaving these contributions to do the best job possible for those who really want and appreciate the plan.

Eligibility. A decision must be made whether to insure all employees or to set up standards of eligibility. As already mentioned, it is common to exclude all employees with less than a specified minimum period of service in order to exclude temporary and transient employees. It is permissible to limit coverage by restricting the plan to certain departments, to the wage roll only, salary roll only, or any other group as long as it does not result in adverse selection. Also, it must be determined whether retired employees, employees temporarily laid off, or employees on leaves of absence are to be covered. Cost is an important factor in these decisions.

Types of Coverage. Under a group life plan, there is little decision involved in type of coverage. The employer needs to decide only whether the plan is to be group term exclusively or whether some group permanent is to be included. In group health there are many decisions to be made: Should the

³¹ This is largely the fault of those employers who fail to "merchandise" their group plans. Group plans should be given publicity on a continuing basis. One way to keep employees reminded of their group insurance is to give each employee an annual statement of how much money the employer has paid in premiums for insurance benefits for that employee.

plan include only hospitalization and surgical benefits (the most widespread coverages in group health)? Should it include loss-of-time coverage (perhaps the most important, since bills can be paid if income continues)? Should it contain provisions for medical reimbursement, diagnostic expense, etc.? Should there be a catastrophe coverage in the form of major medical? If so, should it be integrated with a basic plan or stand alone as the only medical coverage? ³²

The Formula or Schedule. To some extent, the types of coverage purchased will depend on how much the employer feels he can budget for group premiums. The budget is even more important, however, in setting the schedule of benefits. Employers usually like to provide life insurance benefits equal to at least one year's income, although there are many cases where much less than this amount is provided. In health insurance a decision often will have to be made whether to offer a wide range of coverages with low limits or to offer only a few coverages with more adequate limits. From the standpoint of the basic principle of group insurance—to provide a floor of protection—it might seem better to spread the premium money over all possible coverages in order to give the employee some help with any kind of medical bill he might have to pay. However, any group plan will come in for more criticism from employees if it pays what they consider an inadequate amount than if it pays nothing. The psychology of the employees seems to be that if there is no coverage for a contingency that befalls them, it is just "tough luck"; but that inadequate coverage for that contingency is a "cheap plan."

The Company to Buy From. If the employer already has some coverages and is adding more, he usually will want to make further purchases from the same company. Placing all group coverages in one company reduces administrative detail. Moreover, the more insurance an employer has with a given company, the better is his bargaining position on rates, service, and claims. The higher combined premium is likely to result in a lower retention limit.

The reputation of the company for promptness in handling claims and other details of service also will have a bearing—probably more bearing after the plan is installed than before. Most employers assume, unless they have convincing evidence to the contrary—perhaps from another employer—that service from any substantial company will be about the same as that from another. However, after the plan is installed they may become dissatisfied with the

³² Good insurance-buying principles would suggest that there be no coverage for the small, frequent loss which can be budgeted. Insurance should be purchased only for the large, infrequent loss which can not be budgeted. This would suggest that first-dollar coverage be eliminated. Whereas this conclusion would be logical in individual coverage, it is not necessarily so in group coverage. Income tax considerations account for the difference. In employer-financed plans, the cost of the insurance is deductible by the employer and not reportable as income to the employee. The effect is to be able to pay first-dollar losses with tax-free dollars. Also, the cost of trading dollars (which is the case in first-day coverage) is not so expensive in group as in individual coverage because insurers pay out about 90 per cent of the premiums collected. The tax savings more than offset the 10 per cent loading paid to the insurance companies. However, how long 90 per cent plus claim ratios can continue to be paid is open to question.

service and decide to switch the plan to a different company. The ability of the company to meet the desired specifications of the plan can often be an important factor in selection of the company.

A major factor in choice of company in many cases is cost. Costs of identical plans tend to vary among companies, especially after the first year. One of the factors in the rate is the retention limit—the amount of the premium retained by the company for contingencies and expenses. In the larger group case, bargaining over the size of the retention assumes a role in the choice of the carrier. Competition is keen and sometimes even sharp. The size of the retention a company feels it must have is a matter of variables which a company can interpret in a number of ways. The buyer tries to drive down the retention rate³³ and will sometimes consider only the company which offers the lowest one. Differences in retention rates, however, often are small, so that the “price” buyer will usually have several companies from which to make a choice.

One other device sometimes used in competitive bidding in group insurance is the level-commission plan. The agent will request that his commission be loaded in the quoted rate as a level commission rather than as a high first-year commission. This will produce a lower first-year rate and will give the agent a competitive advantage with the strictly price buyer.

In group health insurance, a decision has to be made whether to use the facilities of commercial insurance companies entirely or insure the hospital and surgical exposures with service plans like Blue Cross and Blue Shield. Competition has all but eliminated the many points of difference which formerly existed between the “Blues” and the insurance companies. If the risk is above the average, experience rating might give insurance companies a cost advantage over those “Blues” that do not experience-rate their risks. If the risk is below average, the community rate usually employed by the “Blues” might give the service plan the advantage. Economies of combining all group coverages with one carrier could give insurance companies the cost advantage.

11. SUMMARY.

Group insurance is a plan for covering a large number of people under one master policy issued to employer, union, or association trustees. The employer is the policy owner, and all contractual relationships are between him and the company.³⁴ Individual participants in the plan are not issued policies but are given certificates of participation which summarize the provisions and coverage of the master policy.

Rules for group require that individuals have as little choice in the plan as possible. As a result, antiselection is reduced to a point that need not be considered in underwriting. The underwriting unit is not each individual covered,

³³ In fact, he occasionally succeeds in driving it down to a level that makes many observers of the group business raise their eyebrows.

³⁴ If the policy is with a mutual company, only the employer has a vote for directors. The covered employees, not being policyholders, have no vote.

but the composition and character of the whole group as a unit. For that reason, persons unacceptable on an individual policy basis can be insured under a group plan.

Group is lower in cost and more liberal in coverage than the individual policy. It is lower in cost because (1) commission scales are lower per life; (2) the employer takes over many of the administrative duties; (3) medical examinations are eliminated; (4) the coverage is standardized for the group, thus reducing the insurer's administrative cost; and (5) in the case of group health, the employer has an interest in weeding out false or padded claims in order to control his net premium outlay.

Group insurance makes important contributions to employee relations and employee morale and efficiency, although probably less than advertisements and sales presentations would make it appear. Group does protect the employer against the unbudgetable cost of discharging what has come to be considered his social or moral obligation for the welfare of his employees. Finally, group serves an important social function in offering insurance coverage at a low cost to large numbers of people who otherwise would be without insurance protection.

QUESTIONS FOR CLASS DISCUSSION

1. If you were a life insurance agent, would you like to see the use of group insurance expand? Why or why not?
2. What arguments could you use in a sales presentation for group insurance?
3. Explain why in group life insurance, the average rate is not based on the average age of the participants in the group.
4. If you were an employer, which type of group plan would you take: term or permanent? Why?
5. Why do you suspect that the laws for eligible groups have become more and more lenient?
6. In establishing a group insurance program, what are the decisions that need to be made?
7. If you were designing a group major medical plan, what decisions would you have to make?
8. Although many of the provisions of the group contract are similar to those of the ordinary contract, there are some differences. How do you account for these differences?
9. When you become employed upon graduation and are invited into a contributory group life plan, is it to your advantage to accept the invitation? Discuss.
10. Outline what coverage you would consider essential in an adequate group insurance plan. Would you make the plan contributory or noncontributory? Discuss.

CHAPTER 14

Insurance in Pension Plans

In a basically agricultural economy of small independent farmers who earn their living off the land, the aged can be retained in the family group without too great a financial burden on the family. In a business economy of small proprietors, business owners upon reaching retirement can pass on their interests to their families, in return for which the families will provide the income necessary for support of those retired. Both the retired farmer and retired businessman may wish to render limited services to the farm or business as long as they are useful.

In an economy such as that which exists in the United States today where industrialization, urbanization, big business, and big agriculture are predominant, economic care of the aged often is beyond the financial capacity of the family. In addition, not only is the tradition of the family "caring for its own" breaking down but also its will to do so is.

How to provide economic care for the aged is a significant question. Since efficient and competitive enterprise generally has no place for the superannuated employee, it is often impossible for him to provide income in his old age on a "pay-as-you-go" basis. Therefore, the job of taking care of the superannuated worker and his dependents today seems to fall on (1) the worker's individual ability and effort to amass a competence during his working years, (2) the government, (3) the employer, or (4) some combination of these three.

(1) Self-reliance for old age income is the ideal solution. However, the problem of amassing a competence out of one's own earnings is a difficult one—difficult not only in absolute terms but difficult also in terms of the things that must be foregone during productive years. It is not human nature to give up present things freely for future benefits. Furthermore, mass marketing methods now in vogue do not encourage thrift. The American economy is geared to mass production. To maintain full employment, goods have to be sold so that they do not pile up in the warehouses and lead to a curtailment of production. To sell these goods, distributors resort to powerful advertising and other sales promotion methods. One of the most effective methods has been the development of installment selling with "nothing or little down" and "easy" monthly payments. With effective advertising and sales presentations making man dissatisfied with what he has and with installment selling under the easy

payment plans making it possible for him to buy the things that are supposed to make him happy, there is no wonder that he finds it difficult to save. Actually, instead of saving a part of present income for future use, the tendency is to spend part of the expected future income for present use.

Even if one had a burning desire to save and were not susceptible to high-pressure selling and advertising, he must still face two other obstacles: inflation and the progressive income tax. Inflation is an important economic consideration. The government is committed to a policy of maximum employment consistent with private enterprise. A high level of investment is essential to the maintenance of full employment.¹ A falling price level discourages investment. A rising price level encourages investment. A number of distinguished economists argue that a healthy economy depends upon a gently rising price level. Based on recent historical observation, it is not unrealistic to expect price levels to rise on the average of approximately 2 per cent a year over a working lifetime. Thus the young man who plans his retirement income on the basis of current price levels may find that income grossly inadequate when he reaches old age.

High wages often accompany high prices. However, with the progressive income tax rate the worker retains only a decreasing proportion of each wage increase. Higher wages, therefore, in themselves might not be a solution to the problem of old age financing. Even the higher-paid executive might not be able to plan for his own retirement and still maintain the standard of living expected of him.

(2) A second approach to the problem of financing old age security is for the government to arrange retirement programs. Because of the difficulty the individual faces in accumulating a competence by direct savings, such difficulty being partly the result of government economic policy, the government has found it both economically desirable and politically expedient to enter the old age funding picture. The result is the retirement benefit system under the Social Security Act.² The purpose of Social Security is to provide a floor upon which an adequate retirement income can be built by the individual. The government also plays a role in the retirement picture by granting certain important tax advantages to industrial pension plans approved by the Internal Revenue Service. The nature of and the requisites for these tax advantages will be discussed later.

(3) The third method of handling the problem of old age financing is for the employer to assume some of the burden. Some will argue that the burden is never assumed by the employer because funds used by him to finance

¹ Any major decrease in private investment spending will have to be offset by government spending if the level of employment is to be maintained. Although government economic policy is directed toward the maintenance of private investment spending, it does not preclude heavy increases in deficit-financed government spending, should such a program become necessary for the continuation of economic prosperity.

² Old age assistance on a needs basis also is available from the various states, subsidized under the federal Social Security Act.

retirement benefits are a part of labor cost, which otherwise would have been available for wages.³

Spurred by the rise in the social philosophy of employer responsibility for the welfare of employees and by the demands of organized labor, employers have been entering the field of old age financing in increasing numbers. Today over 25,000,000 people are covered under formal private pension plans. This is more than twice as many as were covered just ten years ago. Assets of pension plans amounted to more than \$45,000,000,000 and are rapidly increasing each year.

1. TAX CONSIDERATIONS IN PENSION PLANNING.

The wishes of both the employer and the employee are subordinate to those of the Internal Revenue Service in pension planning because approval by the Internal Revenue Service is essential if the plan is to enjoy certain tax advantages. Neither the employer nor the employee is willing to put other considerations ahead of tax consequences.

Advantages of Qualifying a Plan. If a plan does not qualify (i.e., does not get the approval of the Internal Revenue Service), contributions made by the employer are both deductible by him and taxable as income to the employee either in the year when a contribution is paid or in the year when a benefit is made available. If the employee's right in the pension is nonforfeitable, the year in which a contribution is paid governs the tax status of the transaction; if the employee's right in the pension is forfeitable, the year in which a benefit is made available governs. By qualifying a plan, the employer may deduct his contributions in the years he makes them, whereas the employee does not report any taxable income until the years in which he receives benefits, regardless of the nature of the employee's rights. The advantage of qualifying a plan, therefore, is to give the employer a current deduction without having his contributions taxed immediately as income to the employee.⁴

Limitations on Employer's Deductions. Section 404 of the Code places certain limitations on the amount of pension contributions that the employer can deduct as a business expense in any one year. The purposes of these limitations are twofold: (1) to prevent the employer from charging off excessive compensation, and (2) to prevent the employer from overfunding the pension to gain tax deductions in what he might consider to be the most favorable years. The restrictions are as follows:

³ This reasoning does not recognize the fact that the employer expects to gain certain additional advantages through granting his employees a pension—advantages which he might not gain by paying out the funds in the form of direct wages.

⁴ Where a trust is used and this trust is exempt under section 501(a) of the Internal Revenue Code, there is an additional tax advantage in qualifying the plan: the earnings of the trust are exempt from federal income taxes. This advantage is important to self-insured (trust-fund) plans where the funds are administered and invested by a trustee. The earnings or assets invested by life insurance companies to fund pension plans are also exempt from income taxes.

(1) Both the contribution (when added to all other employee compensation) and the amount of the pension must be reasonable. This limitation obviously is subjective and general.

(2) More specifically, the employer may deduct up to 5 per cent of the total compensation of covered employees. This maximum may be reduced later if an actuarial analysis reveals that 5 per cent is more than necessary to fund the benefits under the plan. Actuarial data supporting the 5 per cent deduction must be submitted to the Commissioner in the second year and at least every fifth year thereafter. If, as is likely to be the case, the cost of funding the plan exceeds 5 per cent, the excess can be deducted in the year contributed if it does not exceed the aggregate level amounts necessary to fund the pensions for all employees during their remaining service.⁵

(3) As an alternate to the 5 per cent rule, the employer may elect the 10 per cent rule, or what is called the normal cost method of funding. The normal cost is the level amount needed to fund a given pension, assuming contributions are spread over the entire working period of each employee. For those employees who had service prior to the establishment of the plan, a past service liability is created. This liability will equal the sum of the contributions that were missed during the years between the employee's employment date and the installation of the plan, augmented by interest and survivorship benefits based on the actuarial assumptions used in the plan. The 10 per cent or normal cost rule limits the employer's annual deduction to the normal cost of the plan plus 10 per cent of the total past service liability.

If an employer's contribution in any year exceeds the maximum amount allowable, the excess may be carried forward to the first year in which the maximum allowable exceeds the amount contributed.

Requirements for Qualification. Section 401(a) of the Internal Revenue Code sets up several criteria for qualifying a pension plan. The purpose of the standards is to assure a plan is socially beneficial by preventing unfair discrimination. Only those requisites important in qualifying an insured plan are discussed here.⁶

The Irrevocable Plan. In the absence of actuarial or clerical error, the employer must not be allowed to recapture any premiums paid. Dividends or rate credits must be applied to the next premium due. In the event the plan is terminated, the employer is not eligible for a refund until all liabilities under the plan are satisfied.

Fixed Benefits or Contributions. Either the contribution required of the employer or the benefits promised to the employee must be fixed.⁷ If the bene-

⁵ This is subject to the limitation that if the remaining unfunded cost with respect to any three persons is more than 50 per cent of the entire remaining unfunded cost, it must be spread over at least five years.

⁶ A self-insured or trustee plan, sometimes erroneously called self-administered plan, must meet two additional tests: (1) The trust must be created within the United States, and (2) the trust must be for the exclusive benefit of employees.

⁷ Benefits expressed in terms of units as in the variable annuity plans qualify under this provision.

fits are fixed, the cost to the employer can be determined actuarially. If the employer's contributions are fixed, the benefits to the employee may be actuarially determined.

Nondiscriminatory Coverage. A given percentage of employees must be covered. If not, the class of employees to be included must not discriminate in favor of employees who are officers, shareholders, supervisors, or highly paid executives. To meet the percentage requirement, at least 70 per cent of all employees must be eligible and at least 80 per cent of the eligible group must be covered.⁸ As to the nondiscrimination requirement, the Commissioner of Internal Revenue has wide discretionary powers, although certain classifications by statute are not considered discriminatory. A plan may exclude employees whose entire wages do not exceed the maximum under Social Security; or a plan may cover only salaried employees. Any eligibility requirement for coverage such as, for example, workers in a given department or employees with a minimum number of years of service will be acceptable as long as it does not violate the nondiscrimination requirement.

Nondiscriminatory Benefits. The benefit structure must not discriminate in favor of officers, stockholders, supervisors, or high salaried executives. Again the Commissioner has wide latitude in interpreting this requirement, but the statute makes it clear that a plan will not be considered discriminatory simply because the contributions or benefits bear a uniform relationship to the total compensation, or to the basic rate of compensation of such employees.

2. TYPES OF PENSION PLANS.

Pension plans may be informal or formal. If formal, they may be unfunded or funded; and if funded, they may be uninsured or insured.

Informal vs. Formal. The *informal* pension plan is hardly any plan at all. The employer decides whom he will pension and for how much at the time the pension payment commences. The plan is purely discretionary in nature. In practice, of course, retirement ages and incomes by classes of employees do tend to become established under a discretionary plan, but the employee has no contractual assurance that he will receive anything. Thus he has no sound basis for personal financial planning. By and large, such "plans" have not proved a solution to the retirement problem. A *formal* pension plan will define the rights and benefits of the employee in advance, setting forth eligibility standards both for participation in the plan and for the receipt of benefits. It also establishes a formula for the amount of the pension and for any other payments such as death, disability, or severance benefits. The number of informal plans in existence today is insignificant.

Unfunded vs. Funded. Informal plans usually are not funded. A formal plan, however, may be unfunded or funded. When the employer pays the retirement benefits out of current earnings directly to the employees as their benefits mature, the plan is *unfunded*. The unfunded plan is called "pay-as-

⁸ Before applying the percentage, certain employees may be excluded. seasonal workers, part-time employees, and employees with the company less than five years.

you-go," although this designation is not particularly apt. Owe-as-you-go is more fitting terminology because in any formal plan obligations accrue during the employees' working lifetime. If funds to finance them are not set aside in the years the benefits accrue, it is inconsistent to say that the employer is paying as he goes when he is actually owing as he goes.

Plans to pay pension benefits out of current earnings are not generally looked upon with favor. The current income of any business fluctuates, and there may come a time, or times, in the life of the business when current income is insufficient to continue the stipends. Further, businesses are subject to mortalities just as are human beings. The result is that the unfunded plan offers the retired worker no assurance of continued security. It was the financing of pension plans out of current income that led to what might be considered the first crisis in pension planning. Salaries and wages rose during the industrial boom created by World War I. Since most pension plans are based at least in part on the income of the worker, pension plans paid out of current income were strained to meet the cost of benefits to workers who retired at peak salaries.

Shortly following the war came an industrial depression, cutting down the amount of money the employer could pay for pensions out of current income without seriously endangering the solvency of his business. It was then that widespread attention was first given to the use of actuarial and investment principles in pension planning.

The *funded* pension plan is an attempt to handle pension obligations over the years during which they accrue rather than to charge them against current income in the years during which they are paid. One of the oldest and crudest funding devices is the balance sheet reserve. Under this plan, accrued pension obligations are carried as a liability or surplus reserve on the balance sheet. It is a crude method of funding, for it does not earmark *specific* assets for pension financing. It is only slightly removed from the unfunded plans which pay benefits from current earnings. The only difference in the two plans is in the cost accounting. Under the unfunded plan the pension cost is charged as an expense in the year paid, whereas in the so-called balance sheet funded plan the cost of pensions is charged as a reserve to the year in which the liability is incurred. The balance sheet plan gives the illusion of sufficient funds to pay benefits without the necessity of drawing on current income. Also, the tax deduction usually will have to be taken in the year the benefit is paid rather than in the year in which the accrual of pension benefits is charged.

Two prerequisites of sound pension funding are (1) conservative estimates of the future cost of benefits based on sound actuarial data, and (2) the actual deposit of funds into a separate account to be used to pay pension benefits. The balance sheet method does not satisfy the second of these requisites.

Methods of Advance Funding. Several methods of advance funding are available with varying degrees of actuarial soundness. When the employer puts

aside an amount in excess of that required to pay current pension benefits, he is advance funding. When he puts away enough each year to offset his accruing liability (and his accrued liability) based on conservative estimates of mortality, interest, employee turnover, and other variables,⁹ he is fully funded. Whether he has to be fully funded to have an actuarially sound plan is a moot question.¹⁰

The most common methods of advance funding are: (1) terminal funding under which benefits are funded with a single deposit for each employee at the time he retires; (2) entry-age-normal-cost, under which the accruing liability for future service is funded annually on a level-cost basis and the accrued liability for service rendered before the plan was installed is amortized over a given number of years, usually not more than thirty years nor less than the minimum number of years allowed by the Internal Revenue's 10 per cent rule;¹¹ (3) unit-purchase, under which a unit of benefit such as a given percentage of salary is fully funded each year it is earned; (4) level-premium, under which the amount of the pension for each employee is funded by a level contribution made each year until retirement;¹² and (5) aggregate-cost, under which the percentages of the payroll needed annually to fund the aggregate pension liability on a level basis is computed periodically and set aside.¹³

Advantages of Advance Funding. A funded plan has a number of advantages over the unfunded plan, both to the employer and to the employee. The principal advantages are: (1) employees enjoy a feeling of security not associated with an unfunded plan; (2) costs are related to the periods in which they are incurred rather than to the periods in which the funds are disbursed; (3) costs are reduced since tax-free interest can be used to offset some of the pension liability; (4) employees can be asked to share in the financing of the plan; and (5) the plan is less vulnerable to adverse business conditions because a payment to a pension fund can be postponed or suspended with far fewer repercussions than the postponement or suspension of pension benefits.

For these reasons most pension plans are funded.

⁹ Examples of other variables are ages at which employees retire under optional plans, salary rates, and disability rates.

¹⁰ See Dorrance C. Bronson, *Concepts of Actuarial Soundness in Pension Plans*, Richard D. Irwin, Inc., Homewood, Illinois, 1957.

¹¹ The past service liability may be frozen, i.e., not funded in some plans. In these cases only the interest on the past service liability is paid in order to keep it from increasing.

¹² The unit-purchase plan differs from the level-premium plan in that under the unit-purchase plan the cost for each employee is not level but increases each year. The shorter the period between the time the single-premium deposit is made and retirement benefits commence, the less the time over which to earn interest and survivorship benefits. The single premiums for the unit purchases must therefore increase each year for each employee.

¹³ The aggregate-cost method lumps together past service cost and normal cost. It is similar to the level-premium method except that it is computed on a group basis rather than on an individual basis. The percentage of payroll needed must be recomputed periodically to reflect changes in the payroll and in other variables.

Uninsured vs. Insured. Two funding media are available: trust funds and insurance companies. When a trust is used as a funding medium, the plan is called an uninsured or self-insured plan; when an insurance company is used, the plan is called an insured plan; and the use of both media in the same plan is called split funding.

The Uninsured Plan. Under the uninsured plan, a trust fund for the benefit of employees is established. The employer (and in some plans the employee also) makes periodic contributions to the fund in amounts actuarially calculated to fund the pension on the basis of the funding method selected. The employer uses whatever actuarial assumptions (mortality, interest, turnover, salary, retirement, and disability rates) he deems reasonable. Some employers will use more conservative assumptions than others. The amount of the contributions under a given plan will be a function of both the actuarial assumptions and the funding method chosen. The trustee invests the money, accumulates the earnings, and distributes the benefits to eligible employees.

A number of arguments often are suggested in favor of the trust fund plan. These arguments, of course, can be applied soundly only to those corporations large enough to self-insure the pension risk. The advantages claimed are (1) greater economy of operation, (2) greater flexibility in establishing and administering the benefit formula, (3) the possibility of more profitable investment experience since there is more investment freedom,¹⁴ and (4) greater elasticity in funding methods and actuarial assumptions. Nearly all the advantages claimed for the trust fund plan can be matched by the latest forms of insured plans, the newest being the variable annuity which allows insured plans to compete successfully with the trust fund plans in the area of investment. As will become apparent as the discussion develops, the more of the trust fund characteristics that an insured plan assumes, the less of the traditional advantages of the insured plan it retains.

While some trustee plans will provide that the funds shall be invested in immediate annuities at the time an employee retires, these plans, by and large, do not use insurance. Therefore, inasmuch as the subject of this text is insurance and the area of this chapter is insurance in pensions, the mechanics of the trust plan will not be detailed.¹⁵

Insured Plans. In a trustee plan the pension fund stands on its own feet, i.e., there is no averaging of experience with other pension funds.¹⁶ In an insured plan investment experience is averaged among all plans. Mortality experience and administration expenses are partly allocated on an average basis

¹⁴ For a critical appraisal of the freedom allowed in self-administered pension plans see *Labor Law and Industrial Relations* by Charles W. Anrod, Chicago, Institute of Social and Industrial Relations, Loyola University.

¹⁵ For a brief but comprehensive discussion of the trust fund plan and an explanation of its claimed advantages, cf. Hamilton and Bronson, *Pensions*, New York, McGraw-Hill Book Company, Inc., 1958, Chapter 7.

¹⁶ An exception is in the use of common trusts where investment experience is averaged.

and partly based on the performance of the individual plan, with the size of the group controlling the division. In trust fund plans no guarantees are available, whereas the insured plans offer guarantees, the nature and extent of which vary with the type of plan. In a trust fund plan the responsibility for administrative, investment, and actuarial services rests with the employer, trustee, and consulting actuary; in the insured plan the insurance company assumes these responsibilities.

Although insured plans account for less than 25 per cent of all persons covered under private pension plans, they control nearly 40 per cent of the assets held to fund private pensions.

3. TYPES OF INSURED PLANS.

Insured pension plans may be classified broadly into two groups. those using group policies and those using individual policies. Under each general classification are two or more types of plans, each of which will be discussed.

Conventional Group Annuities. The conventional group annuity consists basically of a contract between the employer and the insurance company for the purchase of deferred retirement annuities for each of the employees participating in the plan. As in group life and health, a master contract is issued to the employer, with certificates of participation given to the individuals under the plan. The plan may be either contributory or noncontributory. If the plan is contributory, usually a specified percentage of the number of employees, customarily 75 per cent, will be required to participate. Companies usually set a minimum on the number of lives. The most common limit is twenty-five, although many companies are reducing their requirements to ten; some to even less. As a rule, companies also have a minimum annual premium requirement, making a special administrative charge on cases falling below either a minimum aggregate annual premium or a minimum premium per participant. The purpose of these minimum requirements is to effect the administrative economies responsible for the rate advantage that group has over individual annuities.

The first modern group annuity contract was issued on Christmas Day, 1921. Termed a "group pension plan" at that time,¹⁷ it called for the employer to purchase annually for each employee a single-premium deferred annuity of \$10 a year. Retirement age was 65, at which time the employee

¹⁷ The name was changed to "annuity" because of the disrepute into which the term "pension" later fell as a result of unfavorable experience with non-actuarial pensions. One of the worst of such experiences from a public relations standpoint was that of Morgan & Company, a packing firm which merged with Armour & Company in 1923. Morgan had established a pension plan in 1909, limiting its maximum liability to \$500,000. At the time of the merger, 600 employees had already retired under the plan, and actuaries calculated that over \$7,000,000 would be necessary to pay the promised benefits. A member of the Morgan family voluntarily contributed \$500,000 to the fund, but that succeeded in postponing the debacle by only fourteen months, at the end of which time all benefits ceased, leaving 600 old people "high and dry." The disaster received nation-wide newspaper attention.

would collect a lifetime income equal to the sum of the annuities purchased for his account. Thus, an employee who retired with twenty years of service under the plan would receive an annuity of \$200 a year.

This *unit-purchase* plan is the basic group annuity plan, although today a number of variations have been made in it.

More common than the purchase of annuities of like amounts for each participant is the purchase of annuities varying in amounts according to a schedule of salary brackets. For instance, one amount will be purchased annually for employees earning \$4,000 to \$5,000; another, for employees earning \$5,000 to \$6,000, etc. Since each unit is purchased annually, the total annuity at retirement reflects both the number of years of service of the employee and his salary experience over these years.

Obviously, since years under the plan play a large part in determining the size of the annuity received by the employee, the employee near retirement when the plan is installed will not receive benefits commensurate with his services. A separate formula often is established for past service benefits calling for a lower percentage of earnings. For example, the formula may call for 1½ per cent of earning for each year of future service, but only 1 per cent of earnings for each year of past service. The differential, however, may not discriminate against past service credits because the 1 per cent is applied to the employee's current earnings at the time the plan is installed rather than to the amount he actually earned while rendering the past service. Because of normal increases in earnings over the years of employment, the higher base might compensate for the lower rate. Also, in the case of contributory plans, employee contributions are not retroactive. Since the cost of past service annuities for old employees may be substantial, their purchase is often spread over a period of years, usually in excess of the minimum allowed by the Internal Revenue Service. In most cases some employees will be close to retirement age when a plan is initiated. In some plans these employees are handled by excluding them from the group annuity plan and handling their pensions on a pay-as-you-go basis.¹⁸

The original group annuity plan mentioned earlier provided for the full vesting of each deferred annuity unit in the employee as purchased; i.e., he became the owner of that annuity regardless of future service with the company. Today it is more common in group annuity plans to withhold vesting until the end of a given period of service—maybe ten years; maybe twenty. Any period is possible. A popular arrangement is progressive vesting; i.e., for example, 10 per cent a year beginning with the fifth or tenth year so that the plan is fully vested in fifteen or twenty years. The reason for delayed vesting is to eliminate the pension liability for people who have not rendered the company substantial service. The longer the waiting period required for

¹⁸ Financial considerations may dictate limiting the amount of past service liability an employee can assume. In these cases an employee may exclude a fixed number of years of past service or restrict the number of years of past service counted. Rather than granting a past service benefit as such, some plans set a minimum on the amount of annuity payable.

vesting, the lower will be the probable cost to the employer. Further, withholding vesting may be a factor in reducing employee turnover.

An employee's rights in the annuities in event of termination of employment depend on whether or not the annuities purchased for him are vested. If the plan is noncontributory and not yet vested, he receives nothing. If it is vested, the employee keeps the paid-up annuities already purchased for him. If the plan is contributory but not vested, his contributions—but not those of his employer—are returned to him with or without interest. If the plan is contributory and vested at the time of termination, the employee may withdraw his own contributions in cash and retain the paid-up annuities purchased by the vested portion of the employer's contributions. Or, if he wishes, he can leave his own contributions in the plan to provide paid-up annuities purchased by the vested portion of the employer's contributions. If he elects to keep the paid-up annuities, he still retains the right to withdraw *his own* contributions in cash at any time prior to his normal (65) retirement age. Some contracts offer the employee a vested interest only if he takes his own contributions in the form of a paid-up annuity; if he subsequently cashes out his annuity, he forfeits his interest in the employer's contribution.

Usually the plan forbids the employee to withdraw his contributions prior to termination of employment. In case of death *before* retirement, contributory premiums are returned to the estate or designated beneficiary of the employee; however, it is not common to grant death benefits from the employer's contributions. In case of death *after* retirement, the annuity may or may not pay a refund. The basic annuity purchased with the employer's contributions usually is the pure life annuity.¹⁹ Refund annuities would materially increase the cost as illustrated in Table 23. Employee contributions customarily are used to purchase a *modified* refund annuity calling for a

TABLE 23.

**Single Premiums for Annuities of \$10 Monthly
Commencing at Age 65, Male Lives Only,
Nonparticipating Contracts**

	<i>Age at Issue</i>		
	25	35	45
1. No return on death before age 65 Annuity payments for life only.	\$414	\$541	\$722
2. Return of single premium (or cash value if greater) on death before age 65. Annuity payments for life only.	534	701	919
3. Return of single premium (or cash value if greater) on death before age 65. Annuity payments guaranteed for ten years and life.	580	761	998

¹⁹ Although the pure life annuity is the normal form when the pension is financed entirely by the employer, the employee is usually given the option, subject to certain underwriting controls, to substitute the actuarial equivalent under one of the other forms of annuities.

refund to the deceased's beneficiary or his estate of any amount by which his contributions exceed the total benefits he has received.

While group annuities at one time contained provision for income in event of disability, today it is rare to find such provisions in the conventional group annuity. Provision may be made to allow early retirement for disability within ten years of the normal retirement date at a reduced amount determined actuarially.

When employment is terminated by other than retirement, death, or ill health, nonvested annuities purchased with the employer's contributions are cancelled and their values credited to the account of the employer to be applied toward future premiums. Unless the amount of the cancelled annuities is large, no tangible evidence of good health will be required. If the amount is large, the company may require a medical examination of the terminating employee or may hold up the credit (paying interest on it meanwhile), for, say, five years.²⁰

The company usually reserves the right to modify the terms of the group annuity contract. Any modification or change in the contract is without prejudice to annuities already purchased. Four conditions under which the insurer may discontinue the plan are: (1) nonpayment of premiums, (2) a drop in the number of eligible employees below the minimum required, (3) a drop in the participation percentage in a contributory plan below the required percentage, and (4) refusal of the employer to consent to new conditions imposed under the terms permitting contract modifications. As far as the insured is concerned, the plan may be discontinued at any time.²¹ Annuities already purchased, however, remain in force.

Rates. Rates for the conventional group annuity are based on a modification of the 1951 Group Annuity Mortality Table and 2½ per cent interest.²²

The loading factor is usually 5 per cent to 8 per cent of gross premium, allowing about 3 per cent, on the average, for administration expenses and about 5 per cent for a contingency reserve.²³ Expense loading not actually used is returned in dividends; and excess contingency reserves are released as credits to the employer.

²⁰ Costs under the plan are based on the assumption that premiums paid for those who die before retirement will be used to help pay the benefits of those who outlive the mortality assumptions—just as in the case of any annuity benefits. Therefore, to give credits to the employer on account of the termination of an employee before retirement who is in ill health would be in effect adverse selection and would upset cost calculations. Some companies, however, ignore the health question, granting full credit on termination and adjusting for adverse selection in the dividend or rate reduction formula.

²¹ The Internal Revenue Service places restrictions or penalties on discontinuance of such plans. These restrictions are designed to prevent employee benefit plans from being used as tax avoidance schemes. Also, if the plan is a part of a union collective bargaining agreement, discontinuance will be restricted by that agreement.

²² The GA 1951 Table is based on intercompany mortality experience from 1946 to 1950 with a projection scale to reflect trends in mortality improvement, and a safety margin for the benefit of below average groups. Companies modify this table by setting the age back one or two years and varying the projection scale.

²³ In some states, a contingency reserve is required by law.

It was once the practice to guarantee group annuity rates for the life of the contract. The contract usually provided, however, that rates could be changed on or after the fifth anniversary of the contract but such rate changes would not apply to future annuities purchased for employees who were enrolled in the plan prior to the date of change.²⁴ Since 1935 the general practice has been to guarantee the initial rates for premiums received during the first five contract years only, with changes thereafter applying to everyone under the plan.²⁵ After the first five years, rates may be changed annually.

Rate guarantees and conditions for purchase of annuities for past service credits are the same as those applying to the purchase of annuities for future service credits. Only past credit annuities purchased during the initial guarantee period take the initial rates.

Although only about 18 per cent of the insured pension plans in the United States are conventional group annuities, they cover nearly one-half of all persons covered by insured plans.

Deposit Administration Group Annuity Plan. One objection of the employer to the conventional group annuity is the lack of flexibility in the handling of its costs. The employer's contributions are used annually to buy deferred, single-premium annuities. Employers have been inclined to look with favor on the trustee plan, where the financing is more flexible and the funds are not actually committed on behalf of any one employee until he reaches retirement age. The "deposit administration" variation of the group annuity plan was developed by the insurance companies to offer the employer some of the advantages of the trust fund plan while still offering him an insured plan. The flexibility gained by the deposit administration plan, however, is at the expense of some of the guarantees of the conventional plan.

The deposit administration group annuity retains many of the underwriting requirements and benefit features discussed in connection with the conventional group annuity. Only the basic differences between the two plans are discussed.

Under the deposit administration plan, or DA plan, as it is commonly called, the periodic contributions of the employer are not allocated to the purchase of annuities for a particular employee until he is ready to retire. Instead, contributions are accumulated as a deposit with the insurance company. As each employee becomes eligible for retirement, funds are taken from the account to purchase a single-premium immediate annuity to provide the benefits scheduled under the retirement plan. The annual deposit required of the employer will be the amount the actuary estimates will be needed to

²⁴ At least one prominent company still guarantees the rates through the lifetime of existing employees and reserves the right to change only the rates on new employees. In other words, any rate changes made by this company are effective only on employees placed under the plan subsequent to the rate change.

²⁵ Obviously, the rate changes cannot apply retroactively to annuities already purchased.

fund the plan adequately. The insurance company, however, does not guarantee the adequacy of the fund. The retirement benefit, of course, is guaranteed, once a conversion is made into an annuity. The insurance company will require, however, that the DA fund be large enough each year to purchase the annuities for employees scheduled to retire during that year.

The DA plan gives greater flexibility than the conventional group annuity in the selection of the retirement age and in the establishment of a relationship of benefits to final average salary. No "normal" retirement age is necessary in the deposit administration plan. Instead, an assumed distribution of retirements may be used, based on past experience. That is, the employer surveying past retirement ages determines how many employees may be expected to retire at different ages—or in different age brackets. This distribution may then be used as the assumption for future rates of retirement, thus reflecting costs more accurately than the assumption of a "normal" retirement age of 65, as is common under the usual conventional group annuity plan.²⁶ Further, the deposit administration plan, by postponing purchase of any annuities to actual retirement age instead of purchasing them annually, permits benefits to be based on the final average salary, a figure not determinable until actual retirement is effected.

Since annuities are not purchased until actual retirement, the employer receives no specific credits from the insurer for terminations. This does not mean that the employer receives no cost advantage from a termination. The employer actually receives immediate credit for terminations under the DA plan, since the terminated employee is eliminated from the cost calculation next following his date of termination. Also, allowance may be made for estimated terminations in measuring the size of the deposit the employer is required to make into the fund each year to meet the established schedule of benefits.

The insurance company usually guarantees a minimum rate of interest and the maximum percentage charged for administration on all funds deposited during the first five years. Annuities enter the picture only at the time of retirement of an employee, and their purchase rates are usually guaranteed with respect to all money *deposited* under the contract in the first five years, regardless of when this money is finally applied to buy benefits.²⁷

Under the DA plan, actuarial calculations must be made for termina-

²⁶ While the normal retirement age may be flexible under the DA plan and an average retirement age used in the funding assumptions, the insurance company must insist on a terminal retirement age, at which time the benefits must be purchased if the employee has not retired previously to that date. This is necessary, of course, to prevent the policyholder from selecting against the insurance company by not retiring employees in ill health.

²⁷ Interest guarantees currently are running from 2¾ per cent to 3 per cent. An annual contract charge of several hundred dollars is usually assessed against plans yielding premiums under a given amount. The annuity-purchase rate guarantees are based on interest, mortality, and loading assumptions similar to those used in the conventional group annuity.

tions, salary increases, early and late retirements, etc. The employer is free to hire independent actuarial consultation, or the insurance company will furnish the service. This freedom to use independent actuarial services²⁸ is one of the attractions of the plan. Employers often feel insurance company standards are too rigid and require higher deposits than are actually necessary.²⁹

Immediate Participation Guarantee. Another variation of the group annuity developed to meet the competition of the self-administered plan is the immediate participation guarantee plan, first written in 1950. Sometimes called the "pension administration plan" or "direct-rated deposit administration plan," it seeks to combine the flexibility of self-administered trustee plans with the guarantees of insured plans.

Conventional group annuities and deposit administration plans remove from the control of the employer the deposits made to fund benefits. Further, the employer's participation in any cost savings is deferred through the operation of the dividend formula. Finally, these plans involve the creation of contingency reserves. In competition, advocates of the trust fund plan point out that the uninsured plan enables the employer to keep the funds in his business, reflects immediately any gains in cost factors, and obviates contingency reserves. Instead of having a contingency reserve for losses, such losses are made up by additional contributions to the plan if and as needed. The immediate participation guarantee plan (IPG) seeks to achieve for the employer these "advantages" of the self-insured plan.

IPG is usually written only on very large groups. As in deposit administration, a fund is established into which contributions for the cost of benefits are deposited. This fund is credited annually with the actual net rate of interest earned by the insurance company, including capital gains and losses. A minimum rate of interest usually is guaranteed as in deposit administration. The fund is charged annually with actual administration expenses and credited or charged with mortality gains or losses. Under the IPG plan, no annuities are purchased from the fund when an employee retires as in the DA plan. Instead, all benefit payments are charged directly to the fund. For accounting (valuation) purposes upon the retirement of an employee, the fund is, in effect, debited with the gross single premium for an annuity equal to the amount necessary to pay the scheduled benefits. At the end of the year, any excess of the single premium over the amount paid in benefits is returned to the fund. The fund is then debited for a new annuity for the next year, the rate being at the attained age of the retired employee but on the schedule of rates prevailing at the time of his retirement.

²⁸ Also, the independent pension consultant, who often originates a pension case, more often will suggest deposit administration since it might mean the continuation of his services on a retainer's fee for as long as the plan is in effect, or for as long as he is available, whichever is shorter.

²⁹ Usually, any standard that can be justified on the basis of the employer's past experience will be acceptable to the insurance company.

In other words, everything is handled on an immediate basis, thus giving the employer immediate participation in all cost factors.³⁰ This is one of the characteristics that gives the plan its name. In exchange for this immediate participation, the employer sacrifices many of the guarantees of the conventionally insured plan, and some of those of deposit administration.

In effect, the IPG plan resembles the trustee plan with the insurance company performing the functions of the trustee. One important difference, however, is that once an employee has retired, the insurance company takes over the guarantee of his future benefits instead of leaving this function to the fund. This is the other characteristic that gives the plan its name. It is in this connection that the combination of the flexibility of the uninsured plan plus some of the guarantees of the insured plan is achieved through IPG.

In IPG, the employer is relatively free to make any contribution-rate assumptions he considers reasonable. The insurance company merely sets a minimum and maximum rate of annual contributions. The employer alone is responsible for any deficits which develop in the plan. The one requirement the insurance company has is that the fund be large enough at all times to pay the benefits promised for employees already retired. Should it shrink to that minimum, the contract provides that annuities will be purchased for those already retired. What happens to those under the plan but not yet retired is up to the employer.

In general, the IPG plan guarantees that all money deposited in the plan during an initial period of, say, five years, plus all interest earned on that money, can be applied to the purchase of annuities at a scale of guaranteed rates. After the expiration of the initial rate guarantee, the company is free to alter the rates at which future contributions may purchase annuities.

An IPG plan may be discontinued either by the insurance company or by the employer. If the plan is discontinued, the following alternatives for handling money already deposited are available:

(1) The fund could continue to operate until such time as the amount in it drops to the minimum required, whereupon it would come under the provisions for automatic discontinuance and revert to a closed annuity contract.

(2) The difference between the amount required to buy annuities on

³⁰ Such as mortality improvement, interest earned on funds left with the company, administration expense, turnover. In the self-administered and IPG plans (and, to some extent, in deposit administration), the employer always thinks of this participation in terms of potential gain. Advocates of "immediate participation" will usually illustrate these potential gains in contrast to the conventionally insured plans. Rarely, however, is equal stress given to the potential losses (or increased expenses, to put it another way). "Immediate participation" applies not only to gains but also to losses. This is not intended as criticism of "immediate participation" plans but only of the sales arguments frequently used for them. It should be remembered, also, that the informal, "pay-as-you-go" plan, now generally in disrepute, also gives "immediate participation." The cycle of enthusiasm in any type of "immediate participation" plan follows closely the economic cycles of investment experience. When investment earnings are high, enthusiasm in "immediate participation" is high; when they go down, enthusiasm wanes and employers become more aware of the value of guarantees.

those already retired and the total amount in the fund could be used at the time of discontinuance to buy deferred, paid-up annuities on those not yet retired to the extent of the funds available

IPG contracts sometimes provide that the employer may transfer the IPG funds to another funding agency upon payment of a surrender charge.

The IPG plan is a modification of the DA plan, and together they represent close to one-tenth of all insured plans and protect about one-third of all persons covered under insured pension plans. The DA is the fastest growing type of insured pension plan.

Group Permanent. As explained in Chapter 13, group life insurance can be written wholly or partially in the form of permanent policies as contrasted to the customary one-year term contract. Group permanent may be used to fund a retirement plan as well as to provide a life insurance plan. The general characteristics of group permanent were discussed in Chapter 13 and need not be repeated here.

The policy form most commonly used in group permanent plans (sometimes called group-insurance-annuity plans) is the retirement income contract. Also popular are endowment at age 65, whole life paid up at age 65, and continuous-premium whole life. These forms build endowment or cash values which, under an automatic annuity option, convert to retirement income at retirement age.

The group permanent plan can use a benefit schedule which provides a retirement income based on a flat percentage of salary. Salary usually is considered in terms of brackets with so many units (commonly, \$10 a month ³¹) of retirement benefit purchased on a level-premium basis for each salary bracket. Insurance adjustments resulting from changes in salary sufficient to change brackets are made usually on contract anniversaries. Years of service may be given weight in the benefit schedule by use of a unit of benefit for each year of service rather than a flat percentage of earnings.³²

Group permanent can also use entry age normal or any other basis, depending on what type of group permanent is used.

The group permanent plan will have a normal retirement date as in the group annuity. The selected date is the earliest date for retirement with "full" benefits. If the plan permits early retirement, the available cash value can be used to purchase an immediate annuity of whatever size it will buy at the attained age of the employee. In the case of late retirement, the usual plan is to start retirement benefits at the normal age even if the employee remains at work. The employee might be allowed to defer his retirement by taking the interest-only option, to be converted later to a life income for a higher amount upon actual retirement. While the procedure of delaying retirement

³¹ Some companies offer plans that provide other than \$10 units, the amounts written in any particular case being largely a matter of the relative emphasis in the plan on death and retirement benefits.

³² Death benefits under this plan would increase each year.

and crediting the employer with the benefits not paid can be worked out in group permanent as in the group annuity, the former plan is not so well adapted to the arrangement because of the large death benefits payable upon death before retirement.

In death before retirement, the employee's beneficiary receives the face amount of the insurance on his life. If the plan is based on a retirement income contract, the cash value may be more than the face amount. In that case, the cash value is paid exactly the same as in the case of an individual retirement income insurance policy. Usually the standard forms of settlement options are available to the beneficiary ³³

In case of death after retirement, the benefit payable to a beneficiary varies according to the type of annuity income selected. Usually, the employee may elect any one of the standard annuity settlement options available from life insurance companies in lieu of the customary life income option, if election is made before retirement date. If a life annuity is used, there is no refund. If a life annuity certain has been elected, the remaining certain payments will be made. If a joint-and-last-survivor annuity is elected, payments continue at the same rate or at a reduced rate during the lifetime of the second person.

In event of termination of employment prior to vesting, under noncontributory plans the cash value ³⁴ is credited to the employer to be used for future premiums. If the plan is contributory, the employee's withdrawal value is equal to the cash value on the amount of insurance purchased by his contributions. In more liberal plans the employee's withdrawal value prior to vesting may be his contributions plus interest. If the plan is fully vested, the withdrawing employee is entitled to the cash value on the entire amount of insurance on his life.

The employee may elect to take his withdrawal value in the form of reduced, paid-up life insurance. In that event the amount by which the original insurance exceeds the paid-up benefit may be converted without evidence of insurability to an individual policy of any type except term.

The group permanent contract, like group annuities, may be discontinued by the employer at any time by nonpayment of premium. It may be discontinued by the insurance company if the number of participants or the percentage of participation drops below the required minimums.

Premiums in group permanent plans are level for each unit of purchase. Usually, the initial rate structure is guaranteed for a period of from three to five years. Thereafter, rates may be adjusted, but only as to new entrants into the plan or additional units for those already covered. Dividends are payable

³³ Cash settlement is common.

³⁴ Unlike the cash value of an individual policy, however, that of group permanent is based on the full level reserve. A surrender charge of from \$5 to \$10 per thousand is charged for surrenders during the first policy year. The charge is reduced in subsequent years, and is eliminated after a given number of years, five in some companies, ten in others. The surrender charge allocates a portion of administration costs to the terminated benefits.

under participating contracts and experience credits are granted under non-par contracts.

Individual Contract Pension Trust. In addition to the various group life insurance and group annuity plans for funding the benefits to be paid under a retirement plan, individual life insurance or annuity policies are used. Under these plans, a corporate or individual trustee is set up³⁵ who applies for the policies, holds possession and title to the individual policies, collects the money to pay the premiums, and sometimes receives benefits for payment to the employee or his beneficiary. It is more common, however, for the benefits to be paid directly to the individual.

The individual contract pension trust is most widely used by groups too small to qualify for a trust fund or group plan. Insurance companies engaged in the group business usually will not write an individual contract plan for large groups. (Maxima vary among companies, from 50 to 200.) They prefer to write such groups on a group basis because it is less expensive, easier to administer, and more flexible.

Several types of policies may be written in the individual contract plan as under the group permanent plan; however, again as under the group permanent plan, the most common contract traditionally was³⁶ the retirement income policy, and the most common annuity contract, the retirement annuity. Since retirement income insurance costs only slightly more than the retirement annuity, the insurance form is generally used. One problem with the insurance form is that evidence of insurability is required³⁷. Retirement annuity contracts, however, may be purchased for the uninsurable employees.

The problem of the uninsurable employee has been minimized by the *guaranteed issue* contract, which is now quite common. Under this contract the insurance company agrees to write a maximum amount of insurance on each participating employee without evidence of insurability. The maximum may be a given figure such as \$20,000 or it may be related either to the number of lives covered or to the average amount of insurance written under the plan: ten to fourteen lives, \$10,000, etc.; or three times the average but in no case more than \$20,000.

The individual contract pension trust is adaptable to the customary range of eligibility standards and benefit formulas found in other plans. Some benefit formulas may be awkward to administer, however, requiring the issuing of several policies for each employee throughout his working life to reflect changes in salary brackets. Since some companies will write disability income coverage as riders to individual policies, total and permanent disability in-

³⁵ In order to qualify the plan, and also for administrative convenience.

³⁶ Currently, the trend among pension consultants is a split-funded plan, whole life or life paid up at 65 with a separate investment fund. They consider retirement income plans out-moded for all except very small cases.

³⁷ If the company writes non-medical, only a health statement may be required in addition to other underwriting information. A medical examination will be required for amounts in excess of the non-medical limits.

come protection can be made available with the individual contract pension trust.

Death benefits before retirement under the plan depend upon the type of policy used. If a retirement income policy is used, the death benefit will be the face amount of the insurance or the cash value, whichever is the larger.³⁸ For any other type of life insurance policy, the death benefit is the face of the policy. If the retirement annuity contract is used, the death benefit is the premiums paid or the cash value, whichever is the larger. These death benefits, except for the portion purchased with employee contributions, do not have to be made available to the employee's beneficiary. They can be used by the trustee to pay future premiums on behalf of the employer. The vesting provisions of the plan determine the disposition of the death benefit.

Withdrawal benefits before retirement, in the retirement annuity and the retirement income policy, are the cash values computed according to the terms of the individual contracts. The terminating employee is always entitled to a return of his own contributions, sometimes without but usually with nominal interest. If the plan is not vested, the balance of the cash value of the terminated contract goes to the trustee to be used to finance future employer contributions. If the plan is fully vested, the employee is entitled to the entire cash value of the policy and he has several options in using it. He may continue the contract in force by paying the premiums; he may exercise one of the paid-up options in the policy; or he may elect to collect the cash value either in a lump sum or in periodic payments.

Death benefits after retirement depend, of course, upon the type of annuity settlement used. In the individual-contract pension trust, the basic annuity frequently is life income with a period certain guaranteed. The annuitant, however, may choose the actuarial equivalent under any other of the common forms.

If the individual pension trust is discontinued:

- (1) Cash values can be used to purchase paid-up deferred annuities.
- (2) The employee can take over full premium payments or the policy can be reduced in size if he wishes to pay a smaller premium.
- (3) The cash value of the policies can be made available to employees.

Individual-contract pension trust plans account for about two-thirds of all insured pension plans, but cover less than one-eighth of all persons protected under insured plans.

4. DEFERRED PROFIT-SHARING.

Pensions may be funded through a deferred profit-sharing plan, and by meeting the requirements of the Internal Revenue Service, these plans can also achieve tax advantages.³⁹ The plan appeals to some employers because (1) it gives employees a direct interest in the earnings of the firm and there-

³⁸ See discussion of retirement income policies.

³⁹ Sections 401(a) and 501(a) of the Internal Revenue Code.

fore should promote efficiency, and (2) it does not impose a fixed cost on the employer, except for the requirement that there be frequent and recurring contributions. The second appeal seems to have more influence in the establishment of a profit-sharing pension, whereas the first appeal seems to have more influence in the establishment of a cash distribution, profit-sharing plan.

Reduced to a simple description, the deferred profit-sharing plan, according to the Internal Revenue Service, is a plan established and maintained by an employer to provide for the participation in his profits by his employees or their beneficiaries. The plan must provide a definite predetermined formula for allocating the contributions made to the plan among the participants and for distributing the funds accumulated under the plan. In a profit-sharing retirement arrangement, the funds are held in trust for distribution to employees at retirement or earlier in event of death, disability, or termination of employment.

No definite predetermined formula for determining how profits are to be shared is required, although a formula plan generally is more appealing to employees. In some plans, employees are required to contribute a percentage of salary in order to participate in the employer's contributions.

Full vesting of benefits in event of death usually is provided. Graded vesting in case of termination of employment is customary with a given percentage of vesting occurring after so many completed years of service. Benefits for total and permanent disability may follow a schedule of periodic payments which will continue as long as the disabled employee has an interest in the fund or the employee may be given his full interest in the fund as a lump sum.

The profit-sharing pension trust can be funded with or without life insurance. Several plans are available. (1) The funds can be accumulated and invested by the trustee. At the retirement of each individual the trustee can pay him a monthly income direct from the fund, determined actuarially and in accordance with the distribution formula. (2) All funds can be accumulated and invested by the trustee. At the retirement of each individual, funds to his credit can be used to purchase immediate annuities for whatever amount of benefit the available money will provide. (3) A money-purchase group annuity can be used, under which deferred-retirement annuities are purchased for eligible employees periodically for amounts determined by the size of the profit-sharing fund available. (4) The trustee may use part of the funds to purchase a group permanent plan or individual contracts on participants. Enough funds must be retained by the trust to continue the premium payments in the years that the profit shares fall short of premium commitments. The trustee must be careful also to keep the insurance incidental and subordinate to the retirement benefit or the tax advantages of the plan will be forfeited.⁴⁰

As can be seen, the principal disadvantage of the profit-sharing pension

⁴⁰ Rev. Rul. 57-163, Part 2(k)(2).

plan is that the amount of the benefit is unpredictable; the principal advantage is that the employer is not saddled with a fixed pension cost. To reduce the effect of the undesirable feature of profit-sharing pensions, a basic pension trust plan can be set up to guarantee a minimum retirement benefit, with a modest cost. Then a profit-sharing trust can be established to provide additional benefits, the amount of which depends on the size of the profit-sharing fund accumulated over the years.

5. DECISIONS IN PENSION PLANNING.

Any number of reasons may impel management to install a pension plan for its employees. It may wish to reduce labor turnover, increase employee efficiency, improve employee morale, meet union demands, or insure what it considers to be its social responsibility to take care of its superannuated employees. Whatever the motivating factor or factors, a number of decisions need to be made in formulating a pension plan.

Contributory vs. Noncontributory. As in group life and health insurance, it must be decided whether the plan is to be contributory or noncontributory. Some pension experts favor contributory plans because employee contributions make a more adequate pension possible with a given employer contribution; the employee is likely to be more interested in the plan, understand it better, and appreciate it more if he is asked to contribute to it; and contributory pensions are less paternalistic.

Others favor noncontributory plans because the employer can deduct his contribution for income tax purposes, whereas the employee does not have that privilege. (An employee in a 30 per cent tax bracket would have to earn nearly \$143 to retain \$100 for contribution to a pension fund.) Employers have more freedom in selecting the plan and specifying the benefits; employees might counteract with additional wage demands were they asked to contribute toward a pension; and contributory plans often discriminate against young employees, making it difficult to get them to join the plan.

Eligibility. Another decision relates to eligibility requirements. An employer does not have to cover all employees to qualify his pension plan for tax deduction. He may cover, for example, only salaried workers, or only wage earners, or he may exclude young employees and old employees as classes. A waiting period not to exceed five years is allowed as a prerequisite to eligibility. The plan, of course, must not be discriminatory in favor of officers, stockholders, supervisory employees, or high-salaried employees.

A major problem of eligibility is determining how to provide for employees who are near or past retirement age. Each company must determine its own course, based upon the number of such employees and its financial condition. Many methods of handling the problem are available, running all the way from complete exclusion of employees already at retirement age to granting them full benefits. Where benefits are paid to employees who are near or past retirement age at the time a plan is installed, the benefits often are paid out of current earnings.

Fixing the Retirement Age. The selection of a retirement age is another decision that has to be made. All employees do not become old at the same age; nevertheless, a workable retirement plan must select the retirement age in advance. The most common retirement age is 65, selected to conform to the Social Security retirement age. An age less than 65 might be too expensive. For example, the cost of retiring employees at age 60 is nearly 50 per cent more than the cost at 65.

Many companies have set up minimum and maximum retirement ages, giving employees the option of selecting the year within that range in which they wish to retire.

Benefit Formulas. An important problem in pension planning is the determination of the size of benefits to be paid to employees upon retirement. In arriving at the benefit structure, the employer must make certain that the benefits are not only adequate but also within his ability to pay.

Benefits are usually designed to supplement Social Security payments to a livable level. The amount of benefits may be based on career average earnings, final earnings, average earnings over final five years, average earnings in highest ten years, or any other logical combination. It is generally considered that a pension, to be adequate, should supplement Social Security benefits up to a minimum of 50 per cent of average earnings, at least in the case of lower-income workers. It is also generally considered desirable to give some weight in the pension formula to years of service.

Three widely accepted methods of setting pension benefits are as follows:

(1) *Years of Service.* Under this method, popularly called the unit-benefit method, credits toward the amount of the pension are given for both past and future service. Usually, the amount of the credit for past service is smaller than that for service after the installation of the plan for reasons already given. Some formula such as the following may be used.

<i>Annual Earnings</i>	<i>Percentage Credit per Year of Service</i>	
	<i>Past Service Credit</i>	<i>Future Service Credit</i>
1st \$4,800	0.5%	1.0%
All over \$4,800	1.0%	1.25%

Larger credits often are allowed on earnings over \$4,800 annually because these earnings are not covered by Social Security.

(2) *Flat Percentage.* Under this method a flat percentage, say, for example, 35 per cent or 40 per cent of either average or final salary is provided to all employees completing a minimum number of years of service by age 65. This method attaches no reward to years of service beyond the minimum.

(3) *Money-Purchase.* Under this method a percentage of the worker's pay is set aside by the employer and often matched by the employee. At retirement age this money is available for a pension. The amount of the pension will be the amount that can be purchased with the contributions. Past service benefits and minimum pensions often supplement payments to older workers, since their money-purchase pensions are likely to be inadequate.

Many plans have minima, and a few have maxima. The principal advantage of this method is that the employer's cost is definitely fixed as a predetermined percentage of the subject payroll. The principal disadvantage is that the employee will not know exactly what his pension will be until he retires.

Vesting. Another decision to be made deals with the requirements for vesting. After how many years of service should a terminating employee receive benefits from the employer's contribution to the plan? The principal advantage to the employer of late vesting is lower cost and possibly lower employee turnover. Several advantages of early vesting are:

(1) Better employee relations, since disgruntled employees can leave without losing anything.

(2) Increased interest in the plan among younger employees. A plan under which they must work for years before they own anything in it has little present reality.

(3) Fairness of the plan, since many people will change jobs at least once or twice in a lifetime.

(4) Greater ease in qualifying the plan for tax deduction under the Internal Revenue Code. Vesting is not required for qualification, but technicalities make it desirable. If a plan discriminates in favor of employees who are officers, owners, supervisors, or highly paid workers, or if it is not for the exclusive benefit of employees and their beneficiaries, then it will not meet the requirements of the Internal Revenue Service for favorable tax treatment. Failure to vest may lead to a violation of one of these principles.

Funding Media. Another decision deals with funding media. Should the plan be trustee or insured? If insured, should it be under a conventional group annuity, deposit administration, immediate participating guarantee, group permanent, or individual policies pension trust? Each of these funding media has its uses and limitations. The employer must select the one or combination that best fits his need.

Funding Method. Should the funding method call for terminal funding, age-entry-normal cost, aggregate cost, unit benefit, or level premium. A careful study of the company's financial position, present and anticipated, is vital to this decision.

Pension or Profit-Sharing. A final decision to be made is whether the plan is to be qualified as a pension plan or as a deferred profit-sharing plan. Of the two, the formal pension plan should be selected if the business can finance it. Profit-sharing plans are best used as supplements to basic pension plans.

6. SUMMARY.

The economic problem of the aged in the economy is becoming increasingly acute. Not only is the percentage of the aged to the total population increasing, but it is also more difficult for the average man to prepare for retirement today than it was a generation or so ago. High income taxes and

inflation leave less margin for saving out of current earnings. As a result, building a competence for old age out of individual earnings has become extremely difficult.

One solution to the problem is government participation in old age pensions. The philosophy of the Social Security Act, however, has been to provide only a basic minimum, enough for subsistence level existence. Americans want more than this for their old age.⁴¹

Another solution is for the employer to participate in funding retirement. At the present time the employer has entered into pension funding to a large degree, and all indications are that he will go into it even further as years go by. His participation is fostered both by the government through tax favoritism granted to funds used to establish retirement plans for the benefit of employees, and by union activity.

Retirement plans established by employers may be funded or unfunded; i.e., benefits may be paid on a pay-as-you-go basis or on a basis which calls for the building up of a fund actuarially computed to be sufficient to meet the promised benefits as they fall due.

Funded plans may be trustee, or they may depend on insurance contracts. Insured pension plans may be either on a group basis or on a basis of individual policies. Each plan has variations.

Several types of group plans can be distinguished: conventional deferred group annuities, deposit administration plans, immediate participation guarantee plans, and group permanent. In addition to group plans, pension trust plans investing in individual life insurance and annuity policies are common. Retirement pensions are also funded by deferred profit-sharing plans.

There is no question but that employer participation in retirement financing is of growing importance, economically and socially. Because insurance offers guarantees and administrative help, the insurance plans play an important role in the field of industrial pensions.

QUESTIONS FOR CLASS DISCUSSION

1. What do you think is the best solution to the problem of old age security in this country?
2. How do you account for the vast increase in the number of industrial pensions in this country?
3. If you were advising management on establishing a pension plan, would you recommend a trust fund plan or an insured plan?
4. If, in establishing a pension plan, you find that you have a large number of employees near retirement age, what can you do to handle this problem without increasing the cost of the pension to a prohibitive level?

⁴¹ How far the government should go in providing income for the aged is a question of political philosophy. If this sounds like a "quising" statement, it is meant to be. The authors are not prepared to discuss—in this text, at least—the political aspects of the problem.

5. How would you recommend handling the problem of vesting in a pension plan?
6. Suppose an employer wishes to establish a pension for his employees but does not want a fixed cost. What would you suggest?
7. Under what circumstances would you recommend a deposit administration plan rather than a conventional group annuity?
8. Do you think a pension should be made dependent on a profit-sharing plan? Discuss.
9. Would you recommend the use of the variable annuity in a pension plan? What do you suspect to be the attitude of labor toward such a plan?
10. Discuss the decisions which management must make in establishing a pension plan and indicate how you would go about making these decisions.

CHAPTER 15

Programming Income Insurance: Needs

One of the most frequently asked questions is, "How much insurance should I own?" The best answer is an adaptation of Abraham Lincoln's reputed reply to the query, "How long should a man's legs be?" Lincoln's response was, "Long enough to reach the ground."

Just so, the answer to the question, "How much insurance should I own?" is, "Enough to cover your needs," subject, of course, to the ability to pay premiums. Since most people can use more insurance than their budgets will afford, an intelligent job of insurance buying requires economy in use of dollars available for premiums.

Intelligent insurance buying (or selling) involves the process of programming, because, actually, this process is the only valid way of finding out how much and what kinds of insurance a man should own. Programming involves several steps. First, it consists of analyzing needs; deciding how to cover these needs adequately (tempering wants with ability to pay); and then determining how far present assets,¹ including insurance, go toward filling these needs. From this analysis, the gaps in coverage can be ascertained. The next step is to determine how much and what kinds of insurance are necessary to fill these gaps. The final step involves making recommendations on distribution of policy proceeds, use of dividend options, proper designation of beneficiaries, and consideration of the various policy safeguards available, such as provision for common disaster, spendthrift clause, automatic premium loan, and the like.

It should be noted that the title of this chapter is *not* "Programming Life Insurance," but "Programming *Income* Insurance." It has been demonstrated previously that three perils can interrupt the flow of income: death, old age, and disability. An income insurance program is, therefore, a three-legged stool. To try to base it on two legs—death and old age, as is the case when programming is confined to life insurance holdings alone—is to leave the program in precarious balance.² This discussion of programming, handling

¹ Where there is any significant amount of general property to be taken into account, the process becomes one called "Estate Planning" (to be discussed in Chapter 17).

² This is a concept that is difficult for the experienced life insurance agent to under-

death, old age, and disability needs concurrently may come as a shock to the confirmed life insurance man, but is the only sound concept of programming if there is any real meaning to those clauses calling for complete service to clients in the codes of ethics of such organizations as the National Association of Life Underwriters, American Society of Chartered Life Underwriters, and International Association of Accident & Health Underwriters.³

1. DETERMINING NEEDS.

The first step in programming income insurance is to determine needs. This can be done only on an individual basis. No one set of needs is universally applicable to all policyholders any more than is one set of symptoms universally applicable to every sick man. Likewise, no one arrangement of income insurance policies can be said to fit the typical buyer any more than one medical prescription can be said to be the cure for all physical disorders. Programming, like medical treatment, is entirely an individual thing.

The first step in any discussion of programming is to list and then describe insurance needs. There are a number of uses for insurance. Some of them represent needs, whereas others represent only wants or whims. The interest here is in those basic needs which are not only the most common and widespread but also the most important to the greatest number of buyers.

The following is a list of seven basic insurance needs listed in the order considered by the authors to represent their usual importance to the typical family man.

- (1) Cash needs
- (2) Readjustment income
- (3) Family-period income
- (4) Life income for widow
- (5) Educational fund
- (6) Wife insurance
- (7) Retirement income

Cash Needs. Death or disability of the breadwinner can create a number of needs for a cash fund.

Clean-up Fund. A "clean-up" or "clearance fund" is the first cash need. A man may be completely free from debt before he dies, but his death can

stand, unless he represents one of the life companies that has been in the health insurance business for some time. The typical life agent thinks of writing health insurance as something apart and different from his regular line of work. If he takes disability into consideration in programming, he often thinks he has served his client adequately by arranging waiver of premium—or by selling a small, loss-of-time policy as an afterthought. The established life insurance agent still is a long way from understanding *income* insurance programming; and the training procedures of even the largest life companies now in the health insurance field—with some very few exceptions—do little to show agents the need for integrating the programming of death, old age, and disability needs.

³ Which codes call for professional standards of service.

create expenses that could plunge his estate deeply into debt. The act of dying costs money. To put it callously but nevertheless practically, it will cost money to dispose of the body and for a place to put it. These two costs are inescapable. They are by no means, however, the only possible costs involved.

Few deaths are instantaneous. Usually, there are unpaid bills for medical services, hospital services, nursing care, and other such items which can mount to large sums. In cases of serious illness, no one thinks about economizing or cutting corners on anything that might help. Specialists, treatments, transfusions, operations, oxygen tents, special foods, medicines—anything to keep the patient alive.

Included in the total clearance bill will be outstanding current bills. Few people pay cash day by day. Almost everyone operates at least partly on credit: a charge account at the grocery or drugstore, accounts at department stores, a gasoline credit card, a club account, the utility company services, accrued income taxes. . . . For the thrifty man, living well within his means, these bills may total merely in the tens of dollars, for a good many people, they will run into the hundreds. In cases where there are major obligations outstanding—loans at the bank, an automobile on installments, a mortgage—they may run into thousands.

Finally, if there is any estate other than life insurance left to named beneficiaries, the expenses of probate and administration become involved.

The clearance fund need of the individual does not have to be met by life insurance; but since no man knows when he will die, unless he uses life insurance, he will have to maintain liquid assets equal to whatever cash amount he estimates will be needed at death. Thus, if it is assumed that \$3,000 will be necessary to take care of clearance expenses, then without life insurance, the individual will have to have \$3,000 in liquid assets on hand today, and keep them on hand throughout his future lifetime—a rather large order for the average man. Moreover, under this method, the “clean-up” bill will be paid with 100-cent dollars; that is, a \$3,000 clearance bill will cost \$3,000. On the other hand, if life insurance is used, there is a good chance that the \$3,000 clearance bill will be paid with less than \$3,000. The total cost of a life insurance clearance fund will be the total (net after policy dividend, if participating) of premiums paid plus interest. How much that will amount to depends on the policy used, as shown in Table 24, next page.

Life insurance is the most logical way to provide the money to pay clean-up expenses. The act of dying creates the need for the money; and life insurance proceeds, maturing because of death, furnish the cash to offset death expenses. An asset which has a higher value at liquidation (in this case death) than it has during life is especially valuable for clean-up expenses.

One difficulty involved in programming life insurance for final expenses is that death is not usually instantaneous but often comes after protracted illness which runs up medical and hospital bills. While reasonably accurate

TABLE 24

**Effective Cost per \$1,000 of Clean-up Expense
Insurance Assuming Death at End of Year Indicated**

(All policy forms, representative non-par. Issue age assumed 25)

<i>Year of Death</i>	<i>Premiums Paid Including Interest Foregone *</i>		
	<i>Single Premium Life</i>	<i>20-Pay Life</i>	<i>Continuous-Premium Life</i>
1	\$408	\$25 50	\$17 34
2	416	51.51	35 03
3	424	78 04	53.07
4	433	105 10	71 47
5	442	132.70	90 24
10	488	279 22	189 87
15	538	440 98	299 87
20	594	619.58	421.32
25	656	684 07	555 41
30	725	755 26	703 45
40	883	920.66	1,047.37

* Two per cent interest *net after taxes* is assumed.

estimates can be made of the size of other final expenses, possible medical and hospital bills are a matter of pure guesswork. If they cause the need for cash to exceed the amount of life insurance assigned for clean-up expenses, the rest of the program may be upset. The family will have to dip into policy proceeds intended for other uses. The result is that often, in an attempt to "play it safe," more life insurance is assigned to the clean-up fund than is needed. While it is true that money left after final bills are paid is not lost, it is also true that if the excess money had not been assigned to the clean-up fund, it might have been arranged more suitably in the program.

The solution to this problem is medical expense insurance, using the term in the broadest sense to include all insurable expenses of illness: physician, surgeon, hospital, nurse, drugs, etc. Since such insurance, subject to its maximum, automatically adjusts itself in size of benefits to the size of the bills incurred, the guesswork regarding how much should be allotted for medical expenses in the clean-up fund is reduced.

Since medical insurance should be part of the insurance program of every family, no special medical policy for clean-up purposes is necessary. The same policy that handles medical expenses in case of recovery will pay these expenses in case of death.

Mortgage Insurance. Mortgage insurance is the second cash need most common among life insurance buyers. In most family budgets, mortgage payments (or the monthly rent) are the largest single item, running 25 per cent and sometimes even more of monthly income. Thus, if mortgage payments can be eliminated or even reduced, a much smaller income will suffice to keep the family together. Sufficient insurance therefore should be pro-

vided in a lump sum to pay off the mortgage, if prepayment is acceptable under the terms of the mortgage contract.⁴

Mortgage insurance is an inexpensive way to increase the income of a widow. For example, at age 25, \$61 a year will purchase a \$10,000 mortgage policy on the yearly-decreasing term plan covering a twenty-year mortgage. Assume that the payments of principal and 5 per cent interest on the mortgage are \$75 a month. If the insured dies within the first year, family expenses would be reduced \$75 a month if the mortgage were paid off with the proceeds of the policy. If, on the other hand, the \$10,000 were settled under a twenty-year time option, the policy would pay a minimum monthly income of only \$51.58 (assuming 2½ per cent interest). The family income, therefore, may be increased by as much as \$23.42 a month if the policy proceeds are used to retire the mortgage.⁵

If the mortgage does not allow prepayment, mortgage insurance should be in the form of monthly income payments rather than a lump sum.

Even when the mortgage is paid off, the reduction in housing outlay effected is not the full amount of the previous monthly payments. Under the type of mortgage widely used today, monthly payments include not only principal and interest but also taxes and even insurance. These charges plus normal upkeep and repairs still will have to be met after the mortgage is retired. Therefore, not only cash to pay off the mortgage but also an additional amount of mortgage insurance should be provided to be paid out as monthly income to meet taxes, insurance, and normal maintenance.

The need for mortgage insurance is not adequately covered by death insurance alone. The family economic situation will be just as bad (sometimes worse) in case the bread winner becomes disabled. The situation which gives rise to the need is loss of income. What causes the loss—death or disability—makes little difference in the financial consequences. Therefore, mortgage disability insurance is as necessary as is mortgage life insurance. This, too, must be arranged as monthly income payments to equal the amount of the mortgage obligations.

Emergency Fund. An emergency fund is a third cash need. The best the typical man can do with his insurance program is to provide a minimum livable income for his family in the event of his premature death. Such minima offer no leeway in case of emergencies which require extra cash.

⁴ As pointed out in Chapter 6, too often neither the agent recommending and placing the mortgage insurance nor the mortgagor takes the trouble to check prepayment provisions. As a result, families sometimes find themselves with cash on hand to pay off the mortgage but a mortgage contract which prohibits early retirement. Also, some mortgages will penalize prepayment, especially in the early years of the contract. If there is a penalty provision, then the amount of mortgage insurance should be increased to cover it, if, in spite of the penalty, prepayment is financially advantageous.

⁵ The reason is, of course, that the interest on the unpaid portion of the mortgage is twice as much as the guaranteed interest on the unpaid portion of the proceeds held by the company while making the twenty-year installment payments.

While it is true that when one has a guaranteed income he can obtain credit to pay unexpected bills, repayment of the loan even in small monthly payments may prove an extreme hardship for the family.

In the more adequate insurance program where there is a margin between subsistence and income, the need for emergency cash can be handled by leaving some of the proceeds on interest only with the right to the widow to make withdrawals.⁶

If there is danger that the beneficiary may withdraw funds needlessly, a maximum can be set on the amount of withdrawals at any one time, during any period of time, or in the aggregate. For instance, the right to withdraw might be limited to not more than \$200 in any one year, with the number of such withdrawals limited to five.

In the smaller insurance programs, where a withdrawal of part of the proceeds will reduce the insurance income to a level below subsistence, the problem of extra cash for emergencies is better handled by a special emergency fund. For instance, assume that the minimum family income during the child-raising period is only \$300 a month. Withdrawal of \$1,000 of the proceeds for an emergency (even if allowed by the company) would reduce the income by nearly \$18 a month if five years remained in the child-raising period—a serious cut on a \$300-a-month income. On the other hand, if there is an emergency fund consisting of the proceeds from a \$1,000 policy, the emergency can be met without infringing on the \$300-a-month income.⁷

The emergency fund also provides a safeguard against the effects of inflation. Often a program provides (or a beneficiary elects) an installment income which is adequate for living expenses at the time chosen, only to find that prices have risen to such an extent that this income is no longer sufficient. For instance, a widow with one or two children and a house clear of debt might have found \$150 a month entirely adequate in the late 1930's, only to discover a few years later as prices rose that this income was worth little more than half of its original purchasing power. If there is an emergency fund, the widow can draw upon it by putting it on one of the income options to supplement her \$150 a month. This would ease the situation.⁸

⁶ Also, this right of withdrawal may be set up so as to qualify the life insurance proceeds for the federal estate tax, marital deduction (see Chapter 17).

⁷ If the company will retain an amount as low as \$1,000 on the interest option with the right of withdrawal, then this is the option to use for an emergency fund. If the company will not accept as low as \$1,000 on an interest-only option, then the proceeds should be taken in a lump sum and deposited in a bank to be held for emergencies.

⁸ It is hardly possible that any emergency fund set up under a program calling for \$150 a month income would be sufficient to double that income, but it would help. For instance, such a program would probably call for no more than a \$2,500 emergency fund at best. This amount would provide about \$23 50 a month additional income if put on a ten-year fixed installment basis. Nevertheless, \$173 50 would be better than \$150. Furthermore, the basic principle of programming is to cover the first needs first. Providing income until children reach self-sufficiency (or an age at which they can do at least part-time work to supplement the family income) has a high priority among needs. Thus the children may be nearer the age at which they can help out when the

In addition to inflation, other emergency needs include extraordinary repairs of household equipment, special tax assessments, and the occurrence of major, uninsurable losses or expenses. (Insurable losses should be insured, even by a widow!)

One of the important emergency needs for funds is illness, especially when it requires hospitalization or surgical treatment. As in the case of clean-up, it is impossible to estimate how much might be needed in the emergency fund for medical bills. Rather than tie up money in an emergency fund to meet the unbudgetable expenses of medical care, it is much simpler and more economical to provide for these costs by arranging for enough family income to pay premiums on medical care insurance. In this way these so-called unbudgetable emergency expenses become budgetable. In working out the family's insurance program, therefore, instead of adding, say, \$1,000 to the emergency fund to pay possible medical expenses, it might be better to put a \$1,000 policy on a twenty-year installment option yielding approximately \$60 a year. This additional income would pay the premium on an amount of hospitalization, surgical, and medical expense insurance for the widow and children that would provide benefits, if required, far in excess of \$1,000 in total bills over the twenty-year period.

Actually, as long as insurance is available, laying aside cash in an emergency fund to meet possible medical bills is economically unsound. Insurance programming requires close budgeting and medical care insurance helps make this possible. Only the deductible amounts and the amounts required to offset any co-insurance obligations should be provided for in the emergency fund.

Other Cash Needs. There may be additional cash needs at death if the insured has a sizable bank or policy loan. In such a case, the amount of the loan can be covered with term insurance. In the large estate, cash is needed to pay death taxes. This problem is discussed in Chapter 17.

In summary, it might be emphasized that it is well not to underestimate cash needs. Until a person has firsthand experience, it is hard for him to realize how high the cash needs can run.⁹

Readjustment Income. After cash needs have been taken into consideration, attention must next be directed toward income needs, the most important of which is the readjustment income. Since only few breadwinners,

effect of the inflation is felt. If this is true, the emergency fund can be spread over fewer years with a resulting increase in the monthly benefits. As an example, if only five years of increased income are needed, \$2,500 will pay almost \$45 a month. In larger programs, larger emergency funds can be established to handle the inflation threat more adequately.

⁹ One of the authors has seen family experience in which the amount provided in the clean-up fund was a \$250 industrial policy and the actual costs to be settled (a cancer case), just short of \$10,000. However, this case doesn't prove a need for \$10,000 life insurance assigned to clean-up but for inclusion of medical expense insurance as a part of programming for final bills.

if any, can afford an income replacement program that will permit a family to continue the same standard of living, loss of earned income means family expenditures will have to be cut—usually drastically. However, it is almost impossible for the family to reduce expenditures to a sharply lower level the very instant earned income is interrupted. It takes time to cut living expenses. Acquired buying habits must be replaced. Study must be given to the question of how expenditures can be cut with the least harm to living standards. It may be necessary to dispose of the home and find a less expensive place to live. A change in food habits to less expensive diets might be necessary. The entertainment and recreation budget will have to be sliced. The necessity of cutting these expenses all at once can cause panic that may easily result in a sacrifice of possessions and holdings that, under calmer circumstances, could be liquidated more advantageously. Finally, an immediate reduction in the standard of living with, perhaps, the urgency of the mother seeking early employment, can be devastating to family morale—especially coming on top of the death, shocking accident, or dreaded illness which caused the loss of income.

A family left without earned income might be compared to a family stranded on the top floor of a building without stairway or elevator. A forced jump from the top floor to ground level may seriously injure the family. The readjustment income provides a stairway to bring the family down safely. For example, if net earned income after taxes is \$600 a month, an income insurance program that can provide only \$300 a month in the event of death or disability results in a “long jump” for the family should the insured contingency occur. The distance will be covered with less chance of financial and psychological injury to the family if income can be dropped by stages—say to \$500 the first year, \$400 the second, and reaching the \$300 level by the third. This will give the family time to make an orderly readjustment both in expenditures and in life generally.

In many cases, cash needs and readjustment income will represent the only program a family can afford, particularly in the earlier family years when earnings are relatively low. Such a program means the family will have to earn its own way after the first few years. The readjustment income, however, will give the family time for reorganization. For example, the wife or widow, if she must become the breadwinner, will have the opportunity to take a business college or refresher course in order to prepare herself for a remunerative and responsible position.

It takes little additional life insurance to provide a readjustment period income. Table 25 shows the amount of life insurance required to provide \$100, \$200, and \$300 a month for one, two, and three years.

To provide the readjustment income as suggested in the above family situation calling for a gradual step down from an earned income of \$600 a month to an eventual insured income of \$300 a month would require only \$3,531 of additional insurance. This amount will pay the desired extra \$200

TABLE 25.

**Amount of Life Insurance Required to Provide a Monthly
Readjustment Income (2½ %)**

<i>Years</i>	<i>\$100 a Month</i>	<i>\$200 a Month</i>	<i>\$300 a Month</i>
1	\$1,187	\$2,374	\$3,560
2	2,344	4,688	7,032
3	3,473	6,946	10,420

a month for one year and the extra \$100 a month for the second year.¹⁰ It can be purchased at age 25 on a ten-year convertible term plan for about \$22 a year, less than \$2.00 a month.

The amount of disability income insurance necessary to provide the readjustment income is expressed in terms of the desired income rather than, as in life insurance, in terms of principal amount. The cost of providing a readjustment disability income program is greater than the cost of providing a readjustment income in case of death. For example, a guaranteed renewable disability income policy providing \$200 a month for one year and then \$100 a month for the second year would cost about \$65 a year at age 25 if issued with a four-week waiting period to a man in the most favorable occupational class.

Two factors must be taken into account in the planning of readjustment disability income protection: (1) Company underwriting rules may prohibit the writing of as much disability income insurance as is required to provide a reasonable readjustment income in a given case. The maximum amount allowable may be necessary for the basic income. (2) The additional cost of arranging for the disability income to be paid to age 65 (when it can be replaced by retirement income) rather than for just one or two years is relatively attractive. For example, a monthly disability income of \$100 for one year would cost about \$30 annually. The same income payable to age 65 would cost about \$55, less than twice as much for many more years of protection.

Family Period Income. When cash needs and readjustment income have been taken care of, the next step in the average income insurance program is to provide income for as many of the child-rearing years as possible. The younger the child, the more important is his mother's full-time care. If his mother must work to replace the income shut off by the death or disability of his father, the child has, in effect, lost both parents. Therefore, the insurance program should furnish a livable income for the family at least until the youngest child can become self-sufficient, usually at age 18. It may be contended that it is not ideal for a child to have to work full time as soon as he reaches 18; but the fact remains that by that time, most children are through high school and are at least capable of full-time work. If the family can afford

¹⁰ \$2,344 plus \$1,187 totals \$3,531—\$100 for two years plus \$100 for one year.

enough insurance to provide a family income beyond the youngest child's 18th birthday without sacrificing other important income needs to be discussed later, the family income period should be extended.

Life insurance income for the family period can be developed by stages as the insured's income increases. For example, it could be constructed in blocks of five years each. Table 26 shows the amounts of life insurance neces-

TABLE 26.

Amounts to Provide Monthly Incomes Shown for Subsequent Five-Year Periods (2½%) and for a Total of 20 Years

<i>Monthly Income</i>	<i>First 5 Years Will Require</i>	<i>Second 5 Years Will Require</i>	<i>Third 5 Years Will Require</i>	<i>Fourth 5 Years Will Require</i>	<i>Total Required for 20 Years</i>
\$100	\$ 5,650	\$4,994	\$4,414	\$3,901	\$18,959
150	8,475	7,491	6,621	5,851	28,438
200	11,300	9,988	8,828	7,802	37,918

sary to provide various monthly incomes for subsequent five-year periods and for a total of twenty years.

If there is more than one child, the income can be reduced as each child reaches self-sufficiency. For example, assume a family with three children aged 13, 8, and 3. Assume further that the self-sufficiency age is 18 and that after the death of the father, each child is to receive \$50 a month until he is 18 and that the mother is to receive \$50 a month as long as she has a child under 18 in her care. In insurance planning it must be assumed that death will occur tonight, so the following amounts of insurance will be necessary to fulfill the wishes of the father:

Face amount needed for payments during first 5 years	\$11,300
Face amount needed for payments during second 5 years	7,491
Face amount needed for payments during third 5 years	4,414
Total needed to pay (1) each child \$50 per month until he is 18, and (2) to pay \$50 per month to the mother until last child is 18	\$23,205

If this \$23,205 of life insurance were paid out as a level income over the fifteen-year period, it would provide only about \$160 a month—which would be \$40 a month short of the amount planned for the first five years. Such an arrangement might force the oldest child to seek employment earlier while allowing the youngest child to have the advantages of \$60 a month over the planned minimum. The result would be inequality of opportunity for the children, to say nothing of the hardship to the whole family during the first five years, a time when the oldest child is least able to supplement the family income.

In order to make sure that life insurance proceeds will be paid out in the manner planned in the insurance program, the insured must be careful and

deliberate in the selection of his settlement options¹¹ In the above case, rather than have the entire proceeds settled on a level fifteen-year income basis, a part of the insurance should be settled on a five-year income option, another part on a ten-year option, and the remainder placed on a fifteen-year option. In this way a decreasing amount will be paid each five years as desired.¹²

If the family income period is for more than a few years, as it is likely to be, arranging disability insurance for the family period will call for a combination of separate health insurance policies and disability income riders on life insurance.

Most disability income riders on life insurance require a six-month waiting period. Therefore, they need to be supplemented by other policies.¹³ However, if a readjustment period disability income has been arranged by means of a separate policy, then this income will more than cover the waiting period. The disability income rider can provide the continuing income in event of long-term disability.

Lifetime Income. Planning for a lifetime income after the child-rearing period presents more of a problem in event of death than it does in event of disability. The need for lifetime disability income can be covered adequately for a reasonable premium outlay through disability income riders on life insurance policies. However, the need for a lifetime income for the widow upon death of the insured requires large amounts of life insurance, as indicated by Table 27.

Fortunately, the need for lifetime income is less imperative than for the less expensive income needs previously mentioned. If children can go to work, they can always support a widowed mother or help her support herself. They can also help support a disabled father. However, most people find repugnant the idea of full dependency on their children at any time in life. The responsibility of supporting parents creates a hardship on the children that can be crippling to their economic and even emotional lives. Receipt of such support places the parent or parents in an uncomfortable role. Even if it is not possible to arrange for complete economic sufficiency, provision for at least some income will lighten the burden on the children and give the parents a feeling of some independence. There is a difference between living *with* children and living *off* children. A grandmother who can buy the grandchildren an occasional gift and who can take the family

¹¹ Also, because a program begins going out of date the minute it is set up, periodic reviews are essential

¹² A discussion of the kind of insurance to be used (decreasing term, continuous-premium whole life, endowment, etc.) has been purposely omitted here since the kind of policy to use is a function of a combination of a number of needs rather than of one need. The right kind of policy to use will be discussed in the next chapter

¹³ Group health insurance providing income benefits up to twenty-six weeks or more are gradually becoming the pattern in American industry. These benefits, however, like those in group life, often are inadequate and have to be supplemented by additional coverage written on an individual basis.

TABLE 27.

**Amounts of Proceeds Required to Provide a Woman with
A Guaranteed \$100 a Month of Lifetime Income, No Period
Certain**

(1937 Standard Annuity Table, 2½%, Rated Down Six Years ^b)

<i>Age Income Starts</i>	<i>Proceeds Required</i>	<i>Age Income Starts</i>	<i>Proceeds Required</i>
25	\$34,364	50	24,100
30	32,470	55	21,690
35	30,580	60	19,230
40	28,570	65	16,750
45	26,390	70	14,350

* Company practices vary as to the interest assumptions used and the number of years the table is rated down.

out to dinner now and then seems far less of a burden than one to whom even pin-money must be supplied. It is surprising how much an income as small as \$100 a month can add to the personality of a mother-in-law. This income might even be enough, with a moderate amount of financial help from the children, to allow her to have her own separate apartment, perhaps at less financial expense to the children than the cost of her complete support in their own homes, and certainly at less wear and tear on their emotions.

As said, the financial problem of providing lifetime income in event of

TABLE 28.

**Amount of Annual Premium Needed to Provide \$100 a
Month Lifetime Income from Life Insurance Proceeds
Compared to That Required to Pay \$100 a Month Dis-
ability Income Under a Life Insurance Disability
Income Rider**

<i>Age of Issue and Age Income from Life Insur- ance Begins for a Female</i>	<i>Annual Premium for Required Life Insurance ^a</i>	<i>Annual Premium for Required Dis- ability Income Rider ^b</i>
25	\$190 03	\$42.50
30	190.92	47.18
35	198.16	55.40
40	222.85	66.08
45	273.93	83 00
50	356 68	115.40

^a Figured on the basis of five-year renewable non-par term insurance to reflect actual cost of insurance. Disability income rider will be placed on the permanent insurance contracts in the program or on multiple protection plans.

^b Figured non-par on the basis of \$10 monthly disability income per \$1,000 of continuous-premium whole life and includes waiver of premium. Matures face amount of contract as endowment at age 65 in event of disability before age 60. Premiums are level and payable to age 60.

disability is not as great as that of providing life income in event of death. Table 28 compares the nonparticipating premium outlay required to purchase enough life insurance to provide \$100 a month with the cost of providing \$100 monthly disability income through a life insurance policy rider. In the case of the life insurance illustration, assume the husband and wife are the same age.

The drawback of the disability income rider is that it can be purchased only in combination with life insurance. The rider used in the above table provides \$10 a month disability income for each \$1,000 of face value of life insurance, and, usually, the rider cannot be attached to term insurance. Thus, it is necessary to have \$10,000 of permanent life insurance for each \$100 of monthly disability income needed.¹⁴ Where it is not possible to purchase enough permanent life insurance to provide the needed disability income protection, then it is necessary to purchase separate forms of health insurance.

Educational Fund. Whether, in order of importance, the need for a college education fund for the children should come before or after the life income for the widow depends on the philosophy of the individual insurance buyer. Those who argue for providing college income at the expense of other needs rely on the theory that the more education a child has, the greater will be his earning power and the better able he will be to assume the financial burdens of the family. Statistically, this may be true. For any given child, it may not be. It depends on his aptitudes and general intelligence. The argument also assumes that upon finishing college the children will be willing to support their mother and that their mother will feel easy about accepting their help.

On the other hand, there are those who will argue that if the child is relieved of the financial burden of supporting his mother, he will be in a better position to try to earn his way through college and to build a more normal life for himself after he finishes his education.

About all that can be said of these opposing arguments is that the importance of the college education fund among life insurance needs depends on the circumstances, thinking, and over-all philosophy of each individual family and the vocational interests and abilities displayed by the children. It might be added, however, that with the exception of retirement insurance, life insurance agents find the least buying resistance in the sale of college education insurance.

It is somewhat common to build college funds for children through the purchase of juvenile endowments at age 18. The underlying motive is to

¹⁴ Some few companies will issue only \$5 00 a month disability income per \$1,000 of life insurance. In these companies \$20,000 of permanent life insurance will be needed to buy \$100 a month disability income. At least one prominent company will write \$20 a month per \$1,000 of life insurance, reducing to \$10 at age 60. In this company only \$5,000 of permanent life insurance will be needed to buy \$100 a month disability income. Many companies do not issue the rider at all.

guarantee that funds will be available for college whether the father lives or dies. The motive in itself is a valid one, but there is grave danger in using short-term juvenile endowments unless there is already adequate life insurance to fill the more primary insurance needs of the family: clean-up, mortgage or home maintenance, readjustment, child-rearing period, and life income for the widow. The prospective college freshman first has to finish grade school and high school. A college fund will do little good if sufficient funds are not provided to finance the secondary education.¹⁵ Juvenile endowments generally consume premium dollars which usually can be used better for additional insurance on the breadwinner. Table 29 shows the participating annual premium at various ages of issue for a juvenile endowment at age 18 and the amount of participating continuous-premium whole life and twenty-year term (both with waiver of premium) which the same premium would buy on the life of the father at different ages of issue.

TABLE 29.
The Premium for a \$1,000 Child's Endowment at 18 with Payor Benefits * and the Amount of Continuous-Premium Whole Life and 20-Year Term (both with Waiver of Premium) that Can Be Purchased on the Life of the Father with the Premium on the Juvenile Endowment
(Participating Basis)

<i>Age of Child At Issue</i>	<i>Premium per \$1,000 of Juvenile Endowment Insurance</i>	<i>Assumed Age of Parent</i>	<i>Amount of Continuous-Premium Whole Life (Waiver of Premium Included) that Could Be Purchased on the Life of the Father with the Premium for the \$1,000 Juvenile Endowment</i>	<i>Amount of 20-Year Term (Waiver of Premium Included) that Could Be Purchased on the Life of the Father with the Premium for the \$1,000 Juvenile Endowment</i>
0	\$59 95	25	\$2,956	\$6,595
1	63 59	26	3,054	6,722
2	67 85	27	3,174	6,902
3	72.62	28	3,304	7,120
4	78 05	29	3,452	7,384
5	84.33	30	3,624	7,687

* Provides waiver of premiums if parent dies or becomes disabled before maturity of the policy.

The juvenile endowment with payor benefits including waiver of premiums in the event of either death or disability of the premium payer may be a good way to meet college income needs if the more important family life insurance needs have been met. In the typical family's life insurance

¹⁵ An illustration of the danger of college endowments has been well depicted in a cartoon in an insurance journal: A girl of approximately 18 is shown scrubbing the kitchen floor. In the other room, her employer is saying to a caller: "She's a jewel, but she's leaving to go to Vassar when her educational policy endows this fall."

program, however, it is usually impossible to budget for the relatively high premiums of juvenile endowment.

A more economical method of providing money for college is through term insurance on the head of the family. The term insurance plan provides funds for college education only in case of the death of the father. It provides no funds in case of survival. The plan presupposes that in case the father lives, he will be in a position to finance the college education of his children out of current earnings.

Tables 30 and 31 show how much less expensive it is to guarantee a college education in event of the death of the parent with 20-year term insurance than with juvenile endowment at age 18.

TABLE 30.

**Comparison of Annual Premium to Provide \$100 a Month,
Ten Months a Year for Four Years with Juvenile Endow-
ment at 18 Including Death and Disability Payor Benefits,
and with 20-Year Term Insurance on Life of Parent
(Waiver of Premium Included) at Various Ages of
Issue**

(Participating)

<i>Age of Parent</i>	<i>Age of Child</i>	<i>Juvenile Endowment Age 18</i>	<i>20-Year Term on Life of Parent</i>
25	0	\$221 69	\$40.92
26	1	235 95	42 34
27	2	252.11	43 83
28	3	270 18	45 47
29	4	290 66	47 19
30	5	314.12	49 10

TABLE 31.

**Comparison of Annual Cost of Providing \$200 a Semester
for Four Years to Pay Tuition with Juvenile Endowment
at 18 Including Payor Benefits and with 20-Year Term
Insurance on Life of Parent at Various Ages of Issue**

<i>Age of Parent</i>	<i>Age of Child</i>	<i>Juvenile Endowment Age 18</i>	<i>20-Year Term on Life of Parent</i>
25	0	\$ 89.00	\$16 43
26	1	94.72	17 00
27	2	101 21	17 59
28	3	108.47	18.25
29	4	116.69	18 94
30	5	126 11	19 71

The reduced cost is at the expense of the endowment benefit. The endowment benefit, however, could well be at the expense of an otherwise adequate family insurance program.

Instead of twenty-year term, the college education fund might be provided by use of one of the whole life forms. For example, it takes about \$5,350 of death benefits to provide a college education fund of \$100 a month for ten months and \$200 a semester, over a four-year period. If the father lives until his children reach age 18, the cash value of the whole life policy can be used for the college fund. If taken at age 30, the cash value of a \$5,350 continuous-premium whole life policy at the end of fifteen years would provide one-fourth of the needed income. The cash value of a twenty-pay life for the same amount would yield almost one-half of the needed income. If the child-rearing period income (which would no longer be needed) is provided by a whole life policy, its cash values also can be used to help offset the college income need, if necessary. As will be seen later, however, these cash values probably are earmarked for retirement income.

Providing a college income in event of disability is more difficult than in event of death. It is not possible to arrange a disability income policy or rider that will pay only during the college years.¹⁶ If the juvenile endowment is used to build a college fund, then a "payor benefit" rider, which waives premiums if the parent is disabled, will assure college income. If whole life policies on the life of the parent are used, waiver of premium in event of disability of the payor will insure the cash values for use when the child is ready for college. The only other plan would be to provide excess disability income protection. If disability of the breadwinner occurred a number of years in advance of the time the children are ready for college, the excess income could be accumulated in the bank until needed. If this disability comes when the children are close to college age, the parent could borrow the necessary funds for his child's education on the security of this guaranteed excess disability income which he will collect in the future, assuming, of course, that his life insurance policies, containing waiver of premium, will offer the necessary security in event of death. Company underwriting rules, however, which restrict the amount of disability income insurance that can be written on a life, severely limit the use of this plan.

Wife Insurance. The need for insurance on wives is widely neglected because it is so little recognized.¹⁷ Income insurance is thought of in terms of replacement of *earned* income, and, with typical egotism, the male usually considers himself the only or the major member of the family contributing to earned income. While the wife in a family may not be bringing in a check each pay period, she is providing services that, in the event of her death or

¹⁶ There is no actuarial reason why a delayed-benefit disability income policy could not be devised to pay income over a four-year period starting at a future date coinciding with the time the child would be ready for college. The authors predict its appearance.

¹⁷ One of the authors has been harping on this subject for over a decade and has written articles on it which have been reproduced in sales-idea services and company magazines—with the same general effect as a pebble dropped in the middle of the Atlantic Ocean. Agents commonly ignore the need or relegate it to the position of needs they bring up only after they have covered purely luxury needs.

disability, can be replaced only by a substantial addition to the family budget. Moreover, the income value of the wife's services is both income and Social Security tax-free, whereas the cost of domestic servants is not only subject to Social Security taxes, but is also not fully deductible as an expense for income tax purposes. Therefore, the economic contribution made by the wife to her family is more valuable financially than it appears on the surface. To be more specific, Table 32 shows how much would have to be earned at various income levels to offset the additional cost of an \$1,800-a-year housekeeper.¹⁸

TABLE 32.

Amount That Must Be Earned Before Taxes to Pay a Housekeeper \$1,800 a Year *

(Includes Amount Necessary to Pay Social Security Taxes on Her Wages)

<i>Net Taxable Income</i>	<i>Amount to Earn before Taxes</i>
\$ 6,000	\$2,466
8,000	2,535
10,000	2,687
14,000	2,951
18,000	3,273

* Based on rates for head of household.

Thus, a life insurance policy on the wife paying \$1,800 a year for the services of a housekeeper is equivalent to an increase greater than \$1,800 in the gross income of the widower.

The death of the wife can cause additional losses in the form of (1) clean-up expenses and (2) loss of the income tax savings available under the split income provision of the federal tax law. The first of these losses has been explained. The following example will explain the second. Assume that a husband-father has a taxable income of \$8,000, and that his wife has no independent income. If he files a joint return with his wife, his income tax liability will be \$1,680. Upon the death of his wife, his tax liability will not be affected for the year of her death, but it will be increased by \$156 the first and second year thereafter because he can no longer claim a \$600 exemption for her. Beginning the third taxable year after her death, he will not be allowed to use the rates for married taxpayers filing joint returns but must use the head of household rates. This will increase his tax liability to \$2,000. Therefore, the death of his wife will cost him, ultimately, \$320 a year more in income taxes. If there are no children for whom the widower is entitled to an exemption, then his tax liability will be increased to \$2,164 the first tax-

¹⁸ The tabular figures would be somewhat reduced if the widower qualifies for a tax deduction. If a widower must hire help to care for dependents in order that he may be gainfully employed, the income tax code allows him to deduct the first \$600 of the amount which he pays for the care of a dependent child under twelve years of age or any other dependent physically or mentally incapable of caring for himself.

able year following the death of his wife, an increase of \$484. At higher income levels, the increased tax liability will be progressively more severe.

In addition to the loss of her services, the disability of the wife can cause heavy medical bills, which must be taken into consideration in the planning of medical expense insurance.

Retirement Income. Loss of income can result from superannuation as well as from disability and death. So great a peril is old age that it has been made the subject of social benefits.

To anyone under, perhaps, 45, superannuation seems very distant. Just as it is hard to visualize the horror of a train wreck killing 500 people in China, so it is difficult for the individual of 20 or even 30 to visualize the horror of the inability to earn a living at far-off 65. When the train wreck comes to one's own locality, however, his attitude toward it is much different. Unfortunately, when old age comes to one's own back yard, it is too late to do anything about it. The cure for dependency at 65 is best started at 25.

Too many people, when approached on the subject of systematically planning for old age, casually say: "*I won't live that long; or if I do, I'll have enough in the bank.*"

Men do live; Table 33 shows to what extent.

TABLE 33.

**Expectation of Life and the Chance of Living to 65
Based on the 1949 Annuity Table (without Projection) *
Compiled by the Society of Actuaries**

<i>Age</i>	<i>Age to Which a Man May Expect to Live</i>	<i>Number Out of 1,000 in Each of Ages Shown Who May Ex- pect to Live to Age 65</i>
20	74.23	776
25	74.41	779
30	74.61	782
35	74.85	787
40	75.15	793

* The above table does not take into consideration probable improvements in mortality rates over the future as reflected in the past. If future expectation were considered (1949 Projected Table), the expectations would be 77.68, 77.82, 77.94, 78.12, and 78.39 respectively. The chance of reaching age 65 also would be higher; for example, at age 20 it would be 862 instead of 776 out of 1,000.

Men do live. More than 75 per cent of those at age 20 will attain and pass age 65. The chances of living to retirement are even better at older ages. Moreover, having reached retirement age, the chances of living for a period of years sufficient to consume a large amount of capital are good.

The man who lives to 65 can expect to live to age 80—fifteen more years.¹⁹ If his cost of living in addition to Social Security is as little as \$100 a month, he will in those years use up \$14,858. If he has \$14,858 at age 65

¹⁹ 1949 Society of Actuaries Annuity Table (without projection).

in the bank earning 2 per cent, it would seem that he could reasonably anticipate drawing \$100 a month from principal and interest for the rest of his life. However, should he outlive his age 65 expectancy, he can just as reasonably expect to live about six and three-fourths more years, during which time he will need an additional \$5,100. Men aged 80 have a life expectancy of 6.74 years, to be exact. Each year that a man lives, his probable year of death advances. If he survives his age 80 expectancy and reaches age 86¾, then he may expect to live about four and one-fourth more years, during which time he will spend another \$4,391. As far as the annuity table goes, this process will continue through age 109½. Consequently, to be statistically certain of not outliving his capital when consumed at the rate of \$100 a month, a man aged 65 should have enough to last through age 109½, or \$31,805, an amount a little beyond the accumulation ability of the average man under today's conditions.²⁰

Methods of Protecting Old Age Income. In general, there are seven sources from which the individual who has outlived his earning power can draw money for retirement: (1) charity, (2) government old age benefits, (3) employer pensions, (4) capital, (5) investment income, (6) life insurance, and (7) annuities. Each of these will be discussed briefly.

(1) *Charity.* Charity may come from one of two sources, public or private. The former type includes all institutional charitable sources and all types of township, county, state, dominion, or federal "relief," relief being defined as a stipend based on need rather than vested right. The latter type, private charity, includes any contributions of friends and relatives, especially children.

Aside from the fact that there is no guarantee of future charity, the tradition and principle of independence are so ingrained in the American conscience that few are ever content with charity as a solution to the problem of outliving earning power. No one in planning for financial security has a place for charitable receipts in his plans. Charity is for the man who has had no plan.

(2) *Government Benefits.* Although both the United States and Canada have a system of old age benefits, neither supplies what the typical individual looks upon as enough for reasonable comfort. They provide the base upon which an individual may build his own retirement plan.

(3) *Employer Pensions.* Industrial pensions in many instances supply reasonably comfortable old age income, and an increasing number of people are being covered under private pension plans. However, the mobility of American labor does much to negate the security granted by industrial pensions as many such pensions are now set up.²¹

²⁰ The life expectancy of women is slightly higher. For example, a woman aged 65 may be expected to live to age 83. At 83 she may expect to live to about 87½. Annuity tables for women, however, also go only to age 109 at which age (like men), she has a life expectancy of ½ year.

²¹ Both the number of employer pension plans and the benefits payable by them

(4) *Capital*. Expenditure of capital is an unsatisfactory solution to the problem of old age income because of the large amounts required and because an individual may liquidate his capital before he himself is liquidated.

As has been demonstrated, a man who intends to live off capital must have \$31,805 for each \$100 a month needed to be actually safe. The accumulation of \$31,805 over a forty-year working lifetime requires an annual saving of about \$460.²²

(5) *Investment Earnings*. As a source of old age income, investment earnings eliminate the problem of outliving capital but pose the same problem in regard to accumulation. At $2\frac{1}{2}$ per cent interest net after income tax, it takes about \$48,000 to produce an income of \$100 a month. Over forty years the accumulation of \$48,000 requires a regular annual saving of approximately \$695 at $2\frac{1}{2}$ per cent compound interest, net after taxes. The problem of accumulation is, then, the problem under the investment income plan of providing for old age.²³

(6) *Life Insurance*. A more practical solution to the problem of supplying old age income may be found with life insurance. A premium of \$695 a year at age 25 will buy about \$24,800 non-par retirement income insurance, which will pay \$248 a month for life (120 months certain), starting at age 65. To guarantee an income of \$100 a month to himself, the individual would have to save, not \$695 a year for forty years, as under the investment income plan, but only about \$280—a far more feasible saving and one more likely to be carried through in view of the persuasion of

vary with the ebb and flow of business conditions, and the number of workers covered varies with the ebb and flow of employment. Few pension plans offer adequate vested interest in the employer's contributions to the fund, those being usually forfeitable with severance of employment except after a number of years.

The result is that the typical employee starts in under an employer pension plan, works a few years, and is laid off or changes jobs, forfeiting what the employer has put into the plan for him and probably dissipating the withdrawn accumulation of his own contributions. If the new employer has a plan, the employee must start in "from scratch," probably only to repeat the withdrawing process a few years later, so that even if he reaches retirement age while under some employer plan, he has come under it too late to receive much from it. It is possible that business and industry at large should give consideration to the widespread use of a type of employee pension plan which will (1) not so easily forfeit the employer's contribution, and (2) be transferable: i.e., under which the major portion of such benefits as have been accumulated under one employer will be transferred with the employee when he goes to a new employer, thus making it unnecessary for the worker to start over when he changes jobs.

²² Assuming $2\frac{1}{2}$ per cent compounded annually *net after taxes*, a fair assumption in view of today's rate of return on long-term investments of sufficient safety to justify use in a retirement income plan.

²³ It can be argued that because of the threat of continued inflation and the prospect of an expanding economy, an investment program in mutual funds provides a promising solution to the problem of building funds for retirement. If the funds at age 65 are insufficient to provide an adequate retirement income from investment earnings only without the use of capital, they can be liquidated under the annuity plan, to be discussed later. It should be held in mind, however, that if the annuity plan is purchased at the time of retirement, it will be at the annuity rates in effect many years from now, and the increasing average length of life is increasing annuity rates.

premium notices and the psychology of "giving up something" if the premium is not paid and the policy is lapsed or surrendered. Included in the \$100 a month life insurance retirement plan is \$10,000 protection in case of premature death.

Policy forms other than retirement insurance contracts can be used, as will be discussed later.

(7) *Annuities.* If premature death protection is not needed, annuities offer a slightly less expensive source of retirement income. The annuity is, of course, specifically constructed for the purpose of replacing earning power lost as a result of superannuation. If capital accumulation at retirement age is insufficient either to last long enough if drawn upon or to earn the income required at a safe rate of interest, the capital can be used to purchase an annuity that will (1) do away with the chance that the capital will be exhausted too soon and (2) provide a larger monthly payment than any reasonable interest earning. For example, \$48,000 at $2\frac{1}{2}$ per cent interest will provide \$100 a month. Invested in a single-premium life annuity, it will provide a man aged 65 about \$315 a month, somewhat less for a woman. To put it another way: if the capital accumulation plan has been used to age 65, and there is not the \$48,000 available to yield \$100 a month at $2\frac{1}{2}$ per cent, about \$14,640 will provide the desired income under a straight life annuity. An installment refund annuity of \$100 a month will require a single premium of about \$18,800.

Purchased at age 25, an annual-premium deferred annuity will yield a lifetime income at age 65 of about \$40.70 a month, ten years certain, per \$100 of annual premium. Thus, to build an income of \$100 a month at age 65, a 25-year-old man would have to save about \$246 a year as against \$695 in a capital accumulation and investment income plan where $2\frac{1}{2}$ per cent net after taxes compounded annually is assumed.

If in planning an insurance program for a family, cash value policies of duration at least to retirement age have been used to cover the premature death needs, the cash values of these policies usually will automatically create sufficient retirement income protection for the policyholder if he outlives the need for death protection. For example, a young man who has enough continuous-premium whole life insurance to provide, in case of his death, a life income of \$150 a month for his 30-year-old wife, will also have for his own retirement, should he live to age 65, well over \$100 a month. The cash values of his death protection policies will provide this retirement income despite the fact that he has purchased the policy offering the lowest old age income per \$1,000 of permanent life insurance.

The primary insurance need of the man with dependents is income for these dependents. If he takes care of that adequately with permanent insurance, retirement income will take care of itself.

The needs just discussed are the common needs of the average family, considered in the usual order of their importance. It is well to hold in mind,

however, that income insurance needs are purely personal and differ in some degree in each case.

2. OTHER NEEDS.

The needs which have been discussed up to this point are what are usually considered basic needs. In addition, there are a number of other needs (sometimes whims) which can be satisfied by life insurance. These should be considered only by the few families which have basic needs adequately covered.

"Head-Start Fund." An attractive story can be made of the advantages of buying life insurance on a child at an early age. The purchase, so the story goes, will give a boy a definite financial head start in life in at least two ways: (1) by creating backlog cash values which may be useful in starting him in his business career; (2) by allowing him to take care of his own family needs in the future at a smaller total premium outlay. As an illustration of both of these advantages, note the comparison in Table 34.

TABLE 34.

Comparison of Rates and Values Purchasable with \$100 Annual Premium at Age 10 and 25

<i>Age of Issue</i>	<i>Type of Policy (Non-par)</i>	<i>Face Value</i>	<i>Loan Value at Age 35</i>	<i>Monthly Income Value at 65</i>
10	C-P Whole Life	\$8,250	\$2,250	\$34.00
25	C-P Whole Life	6,000	858	22.75

Travel Fund. Endowment policies are attractive to some families as a means of providing money for extensive travel at some future time. There is a financial disadvantage, however, in using the endowment for this purpose if the savings period is short. Generally, short-term endowments do not show as large a gain over the endowment period as could be earned through even a low-yielding savings account. The endowment policy plan for accumulating a travel fund (or any such special fund) offers two advantages over other methods of accumulation (1) It provides an amount of life insurance protection to be used to supplement other needs until the policy matures. (2) It offers a greater degree of compulsion on the saver to carry his savings plan through to completion.

Dowry for a Daughter. The endowment can be used to provide a dowry for a daughter. Dowries are not a common practice in the United States, but few are the young couples who could not use one in the early years of their marriage, especially in furnishing or building their home. Advantages of using the endowment policy for this purpose are exactly the same as those discussed under the travel fund need.

While the daughter is still dependent on the parent, the dowry policy will serve as clean-up protection for the parental family unit, a family need,

as has been seen. The clean-up use nevertheless would be solely a by-product of the dowry use. A family that can afford the luxury of building a dowry for the daughter could well afford the expense of burial from regular income.

A "Special Dates" Fund. Another luxury use of life insurance is to provide a "special dates," or "anniversary," or "Christmas" fund. A relatively small policy included in the program of the head of the family or of the mother (or of both) will provide the money to buy the requisite gifts on birthdays, anniversaries or, most commonly, at Christmas. A \$1,000 policy will provide a woman aged 35 with about \$40 annually for twenty years certain and life thereafter. This payment may be arranged for December of each year, for example, and may help make Christmas a little more enjoyable for a fatherless family.

Gifts and Bequests. Charitable instincts are not confined to the wealthy. Many men and women of modest means are as much impelled to philanthropy as the million-dollar giver; yet to the person of modest means, what he can give or leave may seem so small as to be unworthy and insignificant. For such a person, life insurance offers a chance to make the gift he never hoped to give—a living gift through endowment insurance or a bequest through life insurance.

For instance, the \$2,500 that may seem like a small bequest will, at age 40, purchase about \$5,000 non-par, single-premium life insurance, or \$3,700 non-par, single-premium, twenty-year endowment.

Still more satisfying are the gifts which can be arranged through annual-premium life or endowment policies. The \$100 a year that seems to the man or woman of 40 an insignificant gift—hardly philanthropy—can be turned into a bequest of almost \$4,000 through use of a non-par, continuous-premium whole life policy.

It is also possible for groups of individuals—a number of alumni, a Sunday School class, a civic club—to arrange a substantial endowment for a charitable, civic, or educational organization by the use of contributions in the form of annual premiums on life insurance on a given member of the group. The charitable institution is named beneficiary. Ten men of about age 35, each of whom would hardly consider himself a philanthropist if he could afford to spend no more than \$45 or \$50 a year for charitable gifts, could arrange a combined gift or endowment of \$20,000 or more through the use of continuous-premium whole life insurance on the life of one of them.²⁴

High income tax rates and high living costs leave fewer free dollars to save, especially after paying today's high living costs. High estate tax rates reduce the proportion of the accumulation which can be passed to heirs. Thus, it has become increasingly more difficult to build family fortunes, with

²⁴ Sometimes individuals take out life insurance policies for their own use, but make the dividends payable to some philanthropic institution. This results in a painless method of giving.

the result that the number of large donors to philanthropic causes and institutions is dropping constantly.

Yet our country looks to philanthropy-supported institutions to supply many of the public's needs and much of its culture.

Without the privately endowed college, for instance, there would be insufficient higher educational facilities in America. Without private money, our library facilities would lag, many phases of social work would be cut off, and churches would be without support. The necessity has arisen, therefore, for replacing the single, \$1,000,000 gift with 1,000 gifts of \$1,000. Philanthropy can no longer depend upon superwealth but must draw from men and women of modest means. Life insurance offers to them—and to philanthropy—a chance to make the insignificant gift grow in size and become the kind of gift an individual feels is worth giving.

Other Luxury Needs. Innumerable other luxury uses could be named for life insurance in a family group and still more might be peculiar to a particular family and its likes. There is insurance for grandchildren, insurance to build a fund to give a daughter a memorable wedding, insurance to help a son set himself up in business, insurance to accumulate a fund to buy a lake cottage, insurance to provide for a daughter's old age—the list is almost inexhaustible. The danger is that since most of these luxury needs have a high degree of sentimental appeal, too frequently they are filled while basic family needs are ignored.

3. SUMMARY.

The summary of this chapter will be deferred to the end of the programming discussion, which is continued in Chapter 16.

QUESTIONS FOR CLASS DISCUSSION

The questions for this chapter are deferred until the end of Chapter 16, which is a continuation of the present discussion.

CHAPTER 16

Programming Income Insurance: Tools and Techniques

Now that the nature of income insurance needs has been established in the foregoing chapter, attention can be turned to the actual process of programming income insurance to cover them.

1. THE TOOLS OF PROGRAMMING.

The purpose of programming is to meet needs; the tools of programming are the settlement options. While the nature of settlement options was described in Chapter 10, a brief review and elaboration of their basic uses¹ are necessary as an introduction to the process of programming.

To repeat: life insurance policies provide for the payment of a stated sum of money upon the death of the insured.² Almost all policies,³ however, provide that at the election of the insured while alive, or at the choice of the beneficiary at the time of settlement, the lump sum of the proceeds will be retained by the company and paid out on any one of the following optional modes of settlement:

Interest Only. The proceeds of the policy may be left with the company at interest. Under this settlement the company pays not less than the guaranteed rate as a monthly, quarterly, semi-annual, or annual income, as desired, except that most companies have some limitation on the minimum amount they will pay in any one installment, such as \$10. If, therefore, the interest paid monthly would amount to less than the minimum, then quarterly

¹ The various uses of each option are somewhat a matter of opinion among different authorities of equal standing. Undoubtedly, therefore, there will be some disagreement with some of the uses suggested here.

² There are some exceptions, such as the family maintenance and family income policies, which call for the payment of an income for a stated period or until a stated date.

³ Group and weekly premium industrial often prove to be the exception. Monthly-premium industrial sometimes provides for limited options; and because of the increasing amounts of insurance offered on the group plan, many permit the fixed-period or fixed-amount options; and a number of group-writing companies will place larger amounts of proceeds on some form of life-income option. The options may be based on rates effective either at the date of the master contract, of the group certificate, and of the request for the settlement agreement, or when the settlement agreement becomes effective, with the date of the master contract being used most frequently.

payments must be elected; if quarterly are smaller than the minimum, then semi-annual payments must be elected, and so on. In most companies the proceeds may be allowed to accumulate at interest during the minority of the beneficiary. Some companies will allow interest to accumulate until the end of a specified period or until a given attained age of a beneficiary when the increased amount is to be applied under another option. Usually, the beneficiary may be given the right to withdraw "in whole or in part," or the insured may have elected to restrict the withdrawals to a maximum amount in any one year. Common situations in which the interest option can be effectively employed are these:

When Cash or Income Is Not Needed at Once. If the program is such that adequate income has been provided for various needs and there is still a sum over and above the amount required for immediate use, selection of the interest option will guard against dissipation of these excess funds.

Deferred Needs. Certain policies may have been arranged to provide cash or income at given future dates, such as during the years the children are in college. The proceeds to fill these needs can be left at interest only until the children are ready for college.

When Uncertain Amounts Are Required. The amount that will be necessary to settle final expenses is never known exactly. Many agents recommend, therefore, that estate settlement funds be left at interest only with the right of withdrawal. Under such a settlement plan, excess amounts are less likely to be dissipated. Moreover, because all bills will not be payable at once, the money will earn interest until at least the anniversary last preceding the date of actual payment. For example, inheritance and estate taxes are not due immediately. Neither are unpaid income taxes. Therefore, funds programmed to pay these taxes should be left at interest and allowed to earn as much as they can until the taxes are due.

The Emergency Fund. That portion of the emergency fund which is left as cash in contrast to the portion insured, as recommended in the preceding chapter, should be left at interest only since it is not to be used until an unforeseen emergency arises. In the meantime it should be earning interest. If paid in cash, theoretically it could be deposited in a savings account and earn interest. However, (1) a savings account may not pay as much interest as is paid by an insurance company under the interest-only option,⁴ and (2) the easy accessibility of bank savings subjects the emergency fund to withdrawal for purposes not wholly emergency in nature.

As a Hedge in Connection with Social Security. Social Security will provide a fairly substantial survivorship income in event of the death of a

⁴ It must be remembered that the insurance companies under participating options pay excess interest above the rate guaranteed under the policy if additional interest is earned. For example, whereas it is customary at this writing for companies to guarantee from 2 per cent to 2½ per cent, many companies are actually paying from 3 per cent to 3½ per cent.

covered worker if he is survived by children under the age of 18. However, the amount the family will receive from Social Security is dependent on the continued life of the children and upon the children's marital status. If a child dies or marries before age 18, his Social Security income terminates. If that child is the only one under age 18 in the family, income to the mother also terminates. As a hedge, therefore, life insurance proceeds may be left at interest, giving the widow the right to withdraw up to a given amount each year to offset any loss of Social Security payments. The use of life insurance for this purpose is closely akin to the emergency fund, of course, and may be considered a part of that fund.

In Event of Common Disaster. Many policies have a "common disaster" clause which provides that upon the death of the insured, the proceeds shall be held (usually at interest) for a specified period and then paid to the primary beneficiary, if surviving, otherwise to the secondary beneficiary; or in the absence of a secondary beneficiary, to the estate of the insured. Thus, if the insured and his wife die "simultaneously" (usually within thirty days of each other, for "common disaster" actually refers to short-term survivorship, not necessarily simultaneous death), the proceeds will not be paid to the widow, and thus will avoid being tied up in her estate.⁵ If a policy does not contain a common disaster clause, or if the time limit in the clause proves to be too short,⁶ the secondary beneficiary can be protected by having the insured leave the proceeds of the policy at interest only, giving the beneficiary the right either to withdraw in whole or in part, or to elect any option in the policy but stipulating that the funds do not legally pass to the beneficiary until actually claimed and paid either in cash or by a settlement direction.

Life Income. If lifetime income is required, a young beneficiary does not usually receive enough more from the life-annuity option than from the interest-only option to warrant liquidation of the principal. For example, \$10,000 of life insurance proceeds under a guaranteed 2½ per cent interest-only option will pay a minimum of \$20.60 a month. If the widow is only 30 years old, an installment refund life-annuity option will guarantee only \$29.80 a month. Generally speaking, if the beneficiary for whom a life income is needed is under age 45 or 50, it will be worth considering the use of the interest-only option, giving the beneficiary the right to change to the annuity option later, if desired.

⁵ In some cases the heirs of the insured and those of the beneficiary will not be identical, particularly in the case of a childless couple. If there is no arrangement for common disaster, it might be held that the beneficiary survived the insured, and, as a consequence, the life insurance proceeds have become vested in her. The proceeds would then pass through her estate to her heirs, whereas the insured might have preferred to have his own heirs enjoy the benefits of his life insurance.

⁶ Suppose the clause provides that in event of the death of the beneficiary within fifteen days of the insured, the proceeds shall not have passed to her. If the beneficiary survives sixteen days instead of fifteen, the insured will not have avoided the situation which he had hoped to avoid through the use of the common disaster clause.

In using the interest-only option, at least two rules should be followed: (1) Life insurance proceeds should not be tied up so tightly that in event of an emergency need they cannot be drawn upon. (2) The beneficiary should not be left an inadequate income from interest in an attempt to preserve principal.⁷

The Fixed-Period Option. The fixed-period option provides for equal payments over a specified period of time. When selected for the beneficiary by the insured, it should be chosen with extreme caution. Although election of, say, the ten-year time option may be justified at the time the election is made, it may be wholly unrealistic by the time the policy matures. Suppose, for example, the option is selected for the readjustment fund. This may be a useful income arrangement when there are dependent children, but if the children are grown by the time the policy matures, the widow might be far better off if the proceeds were paid to her as a life income. Again, educational policies often are arranged to pay proceeds over a fixed period of four years, starting on a given date. Suppose, however, that on that date the son is in the armed forces or the daughter is already married. If the fixed-period option has been elected, the proceeds will have to be paid over the four designated years, regardless of how ridiculous the arrangement might be at the time the policy matures.⁸

The fixed-period option does have some uses:

Where the Amount Is Small. Limited amounts of proceeds may be put on either the fixed-period or the fixed-amount option. Four factors should be considered in making the choice: (1) the possibility of an outstanding loan against the policy at the death of the insured; (2) whether the policy is participating; (3) whether the policy includes a double indemnity clause; (4) whether limited withdrawal privileges are necessary for the beneficiary.

If there is a loan outstanding, it will reduce the amount of each benefit check under the fixed-period option. Under the fixed-amount option, it will reduce the duration of benefits.

If the option is participating, benefits will be increased by any excess

⁷ This is particularly important in view of the fact that increases in living costs may make inadequate in later years an income that seemed reasonably adequate at the time it was selected. A decline in the purchasing power of a fixed-dollar income might have to be offset by drawing on principal or by shifting to an income option paying higher periodic benefits, hence the right to withdraw should be included, and the right to elect another option should also be granted in a special settlement agreement, if the company is willing to do so.

⁸ The argument that the insured can change the election if his situation changes at any time prior to his death is insufficient. What an insured can do and what he will do often are not the same thing. (1) He may die before he realizes that the fixed-period option is incorrect for the new situation. (2) The insureds simply do not review their programs often enough to keep them always up to date. If life insurance agents would more often accept the responsibility of initiating an annual review of the programs of their clients, then the risk of dying with antiquated life insurance settlement options would be substantially reduced. Some companies actively check to make sure that settlement options selected are appropriate.

interest earnings. This increase may be reflected in each benefit check or may be payable annually. Under the fixed-amount option, participation will increase the duration of benefits.

How policy dividends are used also is important. If they are accumulated at interest or are used to buy paid-up additions, the amount of each check is increased under the fixed-period option. Under the fixed-amount option, the duration of benefits will be increased.

Since proceeds payable under a double indemnity benefit usually are merged with the policy proceeds and paid in the same manner, double indemnity benefits increase the amount of each payment under the time option and increase the period over which benefits are paid under the amount option.

Under the fixed-period option, limited withdrawals generally are not allowed. If withdrawal is permitted, the requirement is usually that it be for the full amount—all or none. Partial withdrawals, however, may be provided under the fixed-amount option.

Therefore, whether to put a small amount of proceeds under the fixed-period or fixed-amount option depends on the relative importance of *time* and *amount* in the particular case at hand, and on the importance of granting limited withdrawal rights.

Where the Exact Years of Required Income Are Known. The period of years extending between the time the last child reaches age 18 and the widow becomes 62 is known as the Social Security Blackout Period. During these years the widow is ineligible for Social Security benefits. Life insurance proceeds payable on a fixed-period option may be used to replace the loss of Social Security income during this "blackout" period.

If unusual situations peculiar to a nontypical program should present special reasons for using fixed-period options, they should always be analyzed carefully to determine whether some other option would serve the purpose better.

Specified-Amount Option. Under the amount option, policy proceeds are paid out in installments of a fixed amount until the principal (and interest credited to it) are exhausted. The option, also called "principal and interest to exhaustion," is probably the most widely used option in programming. It is efficient in most small programs, although, in larger programs, interest-only with the right to withdraw is more flexible.

One of the important uses of this option is to provide variable amounts of income from the same policy. For instance, it takes more money to finance a year of high school than a year of grade school. The college years require even more. An educational plan might be arranged under the fixed-amount option whereby an extra \$25 a month (over and beyond the basic family income) is paid during grade school, \$50 during high school, and \$100 during college. The option also is useful for the readjustment income plan, which specifies decreasing amounts of income for several years—say \$600 a month the first year, \$500 the second, and \$300 thereafter.

The specified-amount option is particularly useful in co-ordinating life insurance proceeds with Social Security. Benefits under Social Security decrease as each child reaches age 18. If the family plans call for college, there may be a need to replace the loss in Social Security income by increasing the amount of each income installment provided under a life insurance policy.⁹ The fixed-amount option is the only option under which it is possible to arrange a settlement plan requiring an increase in income at some time in the future.

If, in using the amount option, several policies are involved in making up a given amount of income, the policies should be arranged to pay *concurrently* and not *consecutively*. If two policies are arranged to pay consecutively and one is lapsed or impaired by a loan, there could be a gap between the cessation of payments from one and the beginning of the payments from the other.

The amount option, like the interest-only option, has the advantage of flexibility. Restricted or full withdrawal privileges may be granted. The beneficiary may also be given the right to increase or decrease the amount of each installment within or without limits. The beneficiary may be given the right even to have installments eliminated for certain months during the year—summer, for example, when the children can work or when there are no school expenses.

Life-Income Option. As the name indicates, the life-income option provides income for the life of the payee. In fact, it is often called “the annuity option,” since in effect—if not purely technically—the proceeds¹⁰ of the policy are used by the company to buy a single-premium annuity on the life of the policyholder or beneficiary. The annuity income, however, usually is greater than anything the policyholder or beneficiary could purchase separately with the same amount of money. Purchase of the annuity separately would require payment of acquisition costs, whereas all such costs have already been paid on the life insurance policy before it is converted into an annuity.¹¹

Virtually all policies offer life income on a basis of ten or twenty years certain. In addition, five- and fifteen-year periods are frequently offered as guaranteed minima. Straight life incomes, i.e., with no minimum number of payments guaranteed, also are available. Finally, it is becoming more com-

⁹ This is not a “flaw” in Social Security but a recognition of the fact that at age 18, a child is capable of earning a living without continuing his education. The purpose of Social Security is to provide minimum needs; hence, it provides income until the age at which the average child finishes high school.

¹⁰ Or the cash or endowment value, when the income is to be paid to the policyholder. Some companies will allow endowment proceeds to be put on options payable to other than the insured.

¹¹ “Thus, to advise a beneficiary or policyowner to cash in a policy [or use the proceeds] to purchase an annuity is little short of dishonesty. This is especially true in the case of older policies, as the options available in policies issued some years ago are far more liberal than those in current policies.” Hugh S. Bell, C.L.U., *Up the Ladder to Bigger Sales*, Indianapolis, The Rough Notes Co., 1953, p. 55.

mon to find joint-and-survivorship-life-income options included in the contracts.¹²

The use of the life-income option is practical only when (1) there is a large amount of insurance, and (2) the beneficiary is not too young. Table 35 compares the amount of income available to a female beneficiary on a ten-year certain and life thereafter 2½ per cent option with the amount available under the interest-only option.

TABLE 35.

**Comparison of Monthly Income per \$1,000 of Proceeds
to a Female from Life-Income Option and Interest Option**

(Interest Assumption 2½%)

<i>Age</i>	<i>Life-Income Option</i>	<i>Interest Option</i>
20	\$2.81	\$2 08
25	2.93	2 08
30	3.08	2 08
35	3 26	2 08
40	3.48	2 08
50	4 09	2 08
60	5.01	2 08

Actually, the life-income option is rarely useful in the typical life insurance program for the young man. The usual program does not include enough life insurance to make a life-income option practical. To leave a widow a meager life income that forces her to go to work and "farm out" the children is little better than no income at all. The end result is the same: The children are deprived of a full-time mother. When there is an inadequate amount of life insurance to do a complete job, as is the usual case with the young man, it is far better to cover some needs adequately than to cover all needs scantily.

The most important use of the life-annuity option in programming is to provide a lifetime income for an elderly widow and to arrange the insured's own retirement benefits.

2. THE PROCESS OF PROGRAMMING.

The process of programming income insurance consists of the following steps:

- (1) Determining the nature of each income insurance need.
- (2) Determining how much income should be provided for each of these needs, tempered by what can be afforded.
- (3) Determining how far the following present and expected future

¹² As a matter of company practice, most companies will allow the choice of a joint-and-survivor income—and of other certain-period life incomes—even though not written in the policy. However, often they will require that if an option not guaranteed in the policy is selected, the benefit tables in use by the company at the time the payments begin will be the tables used in computing benefits.

assets can go in meeting the goals: life insurance already owned, estimated Social Security benefits, employer-provided group life and health and pension benefits, and the general estate.¹³

(4) Determining the gaps between the estimated income needs and the amount currently available to meet these needs.

(5) Recommending the kinds and amount of additional insurance to fill as many of the gaps as can be afforded, deciding which needs to cover only partially, and, if necessary, which needs to leave completely uncovered.

(6) Selecting and putting into effect all settlement options and safeguards necessary to the efficient functioning of the program.

To discuss each of these steps briefly:

Determining Needs. As has been said, needs in any given case are individual. Discovering which needs exist is a process of applying the basic list discussed in Chapter 15 to the case at hand. Some will fit; others will not. For instance, the needs of a single man might well be confined to clean-up and retirement; but this cannot be stated as a rule. He might have dependent parents or other relatives, in which case he would have premature death protection as well as clean-up and retirement needs. A childless couple may have only cash needs, readjustment income, income for the widow for life, wife insurance, and retirement.

Two general rules can be stated with reference to determining needs:

(1) *Keep First Needs First.* Some needs have more appeal than others. An example is the educational endowment. It is not at all uncommon for parents to buy high-premium educational endowment policies while leaving the need for grade or high school income inadequately covered. Obtaining a college degree is a fetish in America. The so-called "living needs," such as income for retirement, always seem to have great market appeal. Often, people are quicker to purchase high-premium policies to build up cash values than they are to buy low-premium policies offering more adequate premature death protection.

Another mistake is to insure the lives of children for more than clean-up expenses while the father's protection is inadequate. The motivation often is, "I want to do the things for my children that my parents never were able to do for me." Clear, unemotional thinking on the subject will dictate that the best way to protect the children is to increase the insurance on the life of the father. After all, what has a dead parent done for his child if he has bought \$2,000 of life insurance on his child at the expense of almost \$2,000 of insurance on his own life?

(2) *Looking Ahead.* A young unmarried man may have no need for income for a wife and children, but what are the possibilities of need for it in the future? To the young unmarried man, retirement income has far more appeal than income for a family that does not yet exist. The result is that

¹³ As mentioned, if the general estate is significant, the case becomes one of estate planning, discussed in the next chapter, rather than simple programming.

many a young man has "loaded up" on high-premium retirement insurance before he is married, only to find that in a few years his need for protection is vastly greater—or, at least, more pressing—than his need for retirement funds. At this time, however, too many of his available premium dollars are going into the retirement fund. A sound program not only covers today's needs but also provides flexibility for future needs.¹⁴

Determining Amounts. Far more difficult than determining needs is determining the amount of cash or income necessary to fill them. Obviously, most people would like to replace their income fully so that neither death, disability, nor retirement would materially reduce the family standard of living. The cost of full coverage at any income level, however, is virtually impossible. Table 36 shows the annual premiums necessary to replace \$100 of monthly income lost through death, disability, or retirement.

TABLE 36.

**Annual Premium for Replacing Each \$100
of Monthly Income**

	<i>Age at Which Program is Initiated</i>	
	25	45
Death ^a	\$185	\$260
Disability ^b	65	135
Retirement ^c	275	775
Total	<u>\$525</u>	<u>\$1170</u>

^a Premiums are based on the nonparticipating rate for yearly-renewable term insurance, with a \$12,500 minimum policy. The amount of life insurance needed is figured on the basis of a life-income option. A fifteen-year guarantee is used at age 25 to take care of the child-raising period. No refund feature is used at age 45. It is assumed that the beneficiary is the same age as the insured. The premium rate will increase each year and the amount of insurance will decrease. Since the rate of increase in the charge per \$1,000 of insurance is greater than the rate of decrease in the amount of insurance required, premiums will tend to increase.

^b Figured on the basis of a four-week waiting period with income continuing to age 65 or prior death. Premiums are level and are payable to age 65. Premiums quoted include waiver-of-premium on the life insurance.

^c Figured on the basis of the additional cost required to place enough of the insurance on a nonparticipating endowment at age 65 to provide \$100 a month income on a joint-and-last-survivorship settlement option, minimum policy, \$10,000. Premiums are level and are payable to age 65.

For example, at age 25 the cost of comprehensive income protection is \$525 annually per \$100 a month income, a rate of 43.75 per cent. At

¹⁴ The authors' emphasis on as much protection as possible for each premium dollar should not be taken as advocacy of term insurance for every need. Note the statement here that a sound program provides not only for today's conditions but also flexibility for the future. Just as high-premium endowment policies on a young man do not have sufficient flexibility for the future family protection needs, so term alone does not provide flexibility for future retirement income needs. For the young man, the eventual solution lies somewhere between the two extremes—which solution is usually continuous-premium whole life.

age 45 the annual cost is \$1,170 per \$100 a month, or 97.5 per cent. Thus, it would cost a 25-year-old man, earning \$400 a month net after taxes, \$2,100 a year (\$175 a month) to protect that income against the perils of death, disability, and old age. However, for him to do so even if he could afford it, and in the case of disability income even if the company would write it,¹⁵ would be unrealistic since he would be overinsuring by protecting a \$225 monthly income, net after taxes *and insurance* with \$400 a month. Full insurance would require that he insure only that part of his income in excess of income taxes *and* income insurance costs. Thus, in this case he would insure his income for \$278.26 at a cost of \$121.74.¹⁶ At age 45 the comparable figures would be a \$202.53 monthly income insured for a monthly cost of \$197.47. At other levels of income, net after taxes, the figures at ages 25 and 45 work out as follows.

<i>Monthly Income, Net after Taxes</i>	<i>Age 25</i>		<i>Age 45</i>	
	<i>Monthly-Income Insurance</i>	<i>Monthly Cost</i>	<i>Monthly-Income Insurance</i>	<i>Monthly Cost</i>
\$500	347 97	152 03	253 16	246 84
750	521.74	228 76	379 75	370 25
1,000	695 65	303 35	506 33	493.67
1,500	1,043 48	456.52	759 49	740 51

Study of these figures would clearly indicate that the cost of full coverage would be far beyond what even the most insurance-conscious family would ever consider spending for insurance, and these figures do not even include the cost of insurance to pay clean-up expenses or medical care. The problem of income insurance planning, therefore, is not to get full coverage, but instead to do the best possible job of covering exposures with the amount of money that can be budgeted for insurance. The process of determining the amount of cash and income to be provided usually becomes a problem of deciding upon the minimum amount on which a family can get along. In practice, the agent finds that his job in evaluating needs in programming is to be forever driving down the amounts of cash and income that the prospect insists are necessary. Many agents will approach the problem of determining how much income to assign to each need by first getting a commitment from the family on how much can be budgeted for insurance and then covering as many needs as possible in order of their importance without spreading the insurance too thin.

Subtracting Present Coverage. After the minimum amounts have been determined, the next step in the programming process is to subtract insurance (and other assets) already owned from the total insurance needed.

An important asset in the estate of the typical family man today is So-

¹⁵ Full coverage for the disability income generally is not available since companies place limits on the amount of disability income insurance they will write at various income levels.

¹⁶ $\$278.26 \times .4375 = \121.74 ; $\$278.26 + \$121.74 = \$400$.

cial Security. Potential Social Security benefits for dependents or for retirement total tens of thousands of dollars¹⁷

Another important asset in the typical program is group insurance. Company pension plans also are important. Employee security plans are widespread and are continuing to grow in importance. Even self-employed professional men, through an association group or groups, often have large amounts of group insurance and sometimes even pension benefits

Other types of benefits often encountered are veterans' benefits, railroad and civil service benefits, and teachers' retirement plans. In addition to these, one or more life insurance policies are usually already in force

In the process of programming, it is essential to find at the start, the exact nature and extent of all earning assets and sources of emergency income. Since this discussion is confined to simple programming, income from general property and investments is not considered. Simple programming is, by definition, a process in which general property or assets play no part—usually because there are none of significance. In starting a simple programming case, however, it is well to check for other property and the possibility of a substantial inheritance. The existence of either or both of these may convert what had looked at the start like a simple programming case into one of estate planning.

Recommending Additional Insurance. Just as the amounts of income provided in the average case are a compromise between wants and ability to pay, so the choice of policies to fill the gaps in coverage revealed by programming is often a choice between the best policy for the purpose and the policy for which the insured can afford to pay the premium. For example, while we have seen that permanent policy forms (including non-cancellable health policies as "permanent insurance") are desirable above term for most uses, the premium for permanent insurance necessary to fill all the gaps in a program may be beyond the willingness if not the technical ability of the insured to pay. In such a case, it is up to the programmer whether to recommend that permanent insurance be purchased in the amount of the premium that can be paid and distributed to fill as many gaps as possible or whether to use term and fill all the gaps. The decision will be influenced by two factors. (a) the programming philosophy of the programmer; (b) the character of the insured. For instance, in the case of life insurance, if the insured is of strong character, able to plan ahead and handle money, then convertible term might well be the answer. If he has a habit of spending "over his head," then it may be better to use permanent insurance to fill as many gaps as possible so he will have the cash values to fall back on for premium money in periods when he is "over his head."

¹⁷ The amount of Social Security benefits, being a matter of legislation rather than contract, is changed so frequently that there is little point (and some danger) in quoting exact figures in a book. The reader has no way of knowing from the book itself whether or not the figures quoted are current. Up-to-date figures are available free in pamphlet form from any local Social Security office.

Fitting Needs and Selecting Options. The process of fitting uncovered needs and selecting options is best illustrated by a case example. The following example is deliberately “rigged” to bring out as many facets of the programming process as possible without being completely unreal. Further, it should be remembered that in any given case, there can be as many “valid” program recommendations as there are programmers. The attempt here is not to set up exact rules but to illustrate a process. Different programmers would undoubtedly handle certain points in different ways from those proposed here.

3. A PROGRAM ILLUSTRATION

The program assumes the following facts—

Father

Age	30
Occupational classification	The best
Income (gross before taxes)	\$10,000
(net after federal and state taxes)	9,000 (\$750 mo.)
Obligations	
20-year mortgage	
(original amount)	10,000
(balance now due)	8,000
Present coverages	
Social Security ¹⁸	
For family	
(a) In event of death	
Until older child is 18	254 mo.
Until younger child is 18	191 mo.
Until widow is 62	0
When widow is 62	95 mo.
(b) In event of disability	
Until older child is 18	254 mo.
Until younger child is 18	254 mo.
Until wife is 62	127 mo.
After wife is 62	175 mo. ¹⁹
(c) At retirement	
For husband at 65	127 mo.
For wife at 65 after husband	

¹⁸ As previously explained, Social Security benefits are a matter of legislation, subject to change by any Congress and frequently so changed. The figures used here are to be considered illustrative only. Future changes will alter exact recommendations, however, the attempt is to illustrate a process which remains the same regardless of changes in exact benefits and conditions for receiving benefits. Further, the figures used here are maximums as of the time of writing. Not everyone will receive the maximum, of course. Again, the attempt is not to give an exact recommendation but to illustrate a process.

¹⁹ If she defers benefits to age 65, the amount will be \$191.

is 65 or if he is disabled	64 mo. ²⁰
For widow at 63 or after	95 mo.
(d) Lump sum in event of death	255
Insurance	
Non-contributory Group life	\$10,000
Non-contributory Group pension	Enough to bring his SSA primary benefit up to \$250 a month
20-Pay Life, with Waiver of Premium in event of disability, taken at age 22	2,500
\$5,000 Continuous Premium Whole Life with 1% Family Income rider and Waiver of Premium, taken at age 25	50 mo. to widow's age 48, \$5,000 principal payable at her age 48
Term to 65, with Waiver of Premium in event of disability, taken at age 27	5,000
Hospitalization (\$20 a day board and room for 120 days; \$200 miscellaneous charges; \$300 surgical schedule)	20 day
<i>Mother</i>	
Age	28
Continuous Premium Whole Life, Weekly Premium policy taken at age 11	592
Hospitalization	20 day
<i>Son</i>	
Age	5
Endowment at Age with Payor Benefit (Premiums waived in case of death or disability of father), taken at age 2	1,000
Hospitalization	20 day
<i>Daughter</i>	
Age	3
Endowment at Age 18 with Payor Benefit, taken at age 0	1,000
Hospitalization	20 day

²⁰ She can start the benefits at 62 if husband is disabled. If she does, the total for her and her husband will be about 92 per cent of amounts shown for them under "(c)." If she draws benefits by reason of his retirement as contrasted to disablement, she cannot start them until age 63. A wife is eligible for retirement benefits on her husband's account at her age 62 or any time after that he retires. This wife, being only two years younger than her husband, cannot draw retirement benefits until she is 63. If she starts them then, the total of her and her husband's benefits will be about 94 per cent of that shown. If she waits until 64, the total will be about 97 per cent.

Husband and wife agree that the family could get along on approximately \$350 a month until the children are grown if most of it were to be tax-free—as income is when received in the form of insurance and Social Security benefits. After the children are grown, they feel they could get along on \$250 a month as a bare minimum. In event of his death or disability, they would like to keep the house, but they would give up the car.²¹ They further feel (and a check of their average of bills outstanding, accrued taxes, etc. bears them out) that the \$255 lump sum from Social Security plus \$1,000 from insurance would take care of the father's *predictable* final expenses. However, they realize that only when a man dies instantly are there no final medical expenses; therefore, they wish to add \$1,000 to the \$1,255 for such final bills. Finally, they agree they can put an additional \$20 a month into insurance premiums.

Present Situation in Event of Disability or Death. In determining protection needs, the only safe assumption to make is that death or disability will occur tomorrow. Based on that assumption, and in light of the family's "wants," their present coverages might be distributed as follows:

FINAL EXPENSES—

<i>In event of death of father</i>		\$2,255.00 ²²
From Social Security lump sum death benefit	\$ 255.00	
From the \$10,000 group life	2,000 00	
Plus \$20-a-day hospital plan		
<i>In event of death of mother</i>		\$ 592.00
From Weekly Premium policy	\$ 592.00	
Plus \$20-a-day hospital plan		
<i>In event of death of either child</i>		\$1,000.00
From the Endowments at 18	\$1,000.00	
Plus \$20-a-day hospital plan		

MORTGAGE—

<i>In event of death of father</i>		\$8,000.00
From the \$10,000 group life	\$8,000.00	
<i>In event of disability of father</i>		\$ 0

EMERGENCY FUND—

<i>In event of death of father</i>	<i>Whatever is left after final expenses</i>
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MEDICAL CARE COVERAGE—

In case of hospitalization of any family member, \$20 a day room and board plus \$200 miscellaneous charges and \$300 surgical schedule.

UNTIL SON IS 18—

<i>In case of death of father</i>	\$ 319.63 mo.
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²¹ *Somewhere* there must be a real family that does not feel an automobile is essential to its morals and very existence

²² Added to this might be some death benefit or cash value from the pension plan; but since the amount would depend entirely upon the plan, it is omitted here.

From Social Security	\$ 254 00 mo.	
From the family income rider	50 00	
From proceeds of \$5,000 term to 65 and \$2,500 20-pay life held at 2½% under interest-only option	15.63	
<i>In case of disability of father</i>		\$ 254.00 mo
From Social Security (after waiting period)	\$ 254 00 mo.	
FROM SON'S AGE 18 AND ENTERING COLLEGE TO DAUGHTER'S 18 AND ENTERING—		
<i>In case of death of father</i>		\$ 278.48
From Social Security	\$ 191.00	
From family income rider	50.00	
From interest on term and 20-pay	15.63	
From son's Endowment at 18, paid out in equal installments for four years	21.85	
<i>In event of disability of father</i>		\$ 254.00 mo.
From Social Security	\$ 254.00	
FROM DAUGHTER'S AGE 18 TO SON'S AGE 22—		
<i>In event of death of father</i>		\$ 208.10 mo.
From Social Security	\$ 0	
From family income rider	50.00	
From proceeds of the term policy, paid principal and interest to ex- haustion (Will last approximately 5 years.)	91.90	
From proceeds of the 20-pay life, paid principal and interest to ex- haustion (Will last approximately 10 years.)	22.50	
From the Endowments at 18 on both children	43.70	
<i>In event of disability of father</i>		\$ 127 00 mo.
From Social Security (reduced be- cause no benefits are any longer payable to children—unless they themselves are disabled from a disability starting before age 18 —and when none are payable to children, benefit to wife of dis- abled worker ceases)	\$ 127.00	
FROM SON'S AGE 22 AND GRADUATION FROM COLLEGE TO DAUGHTER'S AGE 22—		
<i>In event of death of father</i>		\$ 186.25 mo.

From family income rider	\$ 50.00	
From proceeds of the term policy	91.90	
From proceeds of the 20-pay life policy	22 50	
From E 18 on daughter	21.85	
<i>In event of disability of father</i>		\$ 127 00 mo.
From Social Security	\$ 127.00	
FOR 1 YEAR AFTER DAUGHTER IS 22 (TO MOTHER'S AGE 48)—		
<i>In event of death of father</i>		\$ 164.40 mo.
From family income rider	\$ 50.00	
From proceeds of term policy	91 90	
From proceeds of 20-pay life policy	22.50	
<i>In event of disability of father</i>		\$ 127 00 mo.
From Social Security	\$ 127.00	
FROM MOTHER'S AGES 48 TO 53—		
<i>In event of death of father</i>		\$ 114.40 mo.
From proceeds of basic \$5,000 policy to which family income rider was attached, paid out principal and interest to exhaustion. (Will last about 5 years.)	\$ 91.90	
From 20-pay life proceeds	22.50	
<i>In event of disability of father</i>		\$ 127.00 mo.
From Social Security	\$ 127.00	
FROM MOTHER'S AGES 53 TO 62—		
<i>In event of death of father</i>		\$ 0 mo.
<i>In event of disability of father</i>		\$ 127.00 mo.
From Social Security	\$ 127.00	
FROM MOTHER'S AGE 62—		
<i>In event of death of father</i>		\$ 95.00 mo.
From Social Security	\$ 95 00	
<i>In event of disability of father</i>		\$ 127.00 mo.
From Social Security	\$ 127.00	
FROM MOTHER'S AGE 63—		
<i>In event of death of father</i>		\$ 95.00 mo.
From Social Security	\$ 95.00	
<i>In event of disability of father</i>		\$ 326.03 mo.
From his Social Security old age benefit (which is same as disability benefit he has been receiving)	\$ 127.00	
From Social Security old age benefit for wife of worker who is 65 or over when she becomes 63. (If she waits until 65 to start her		

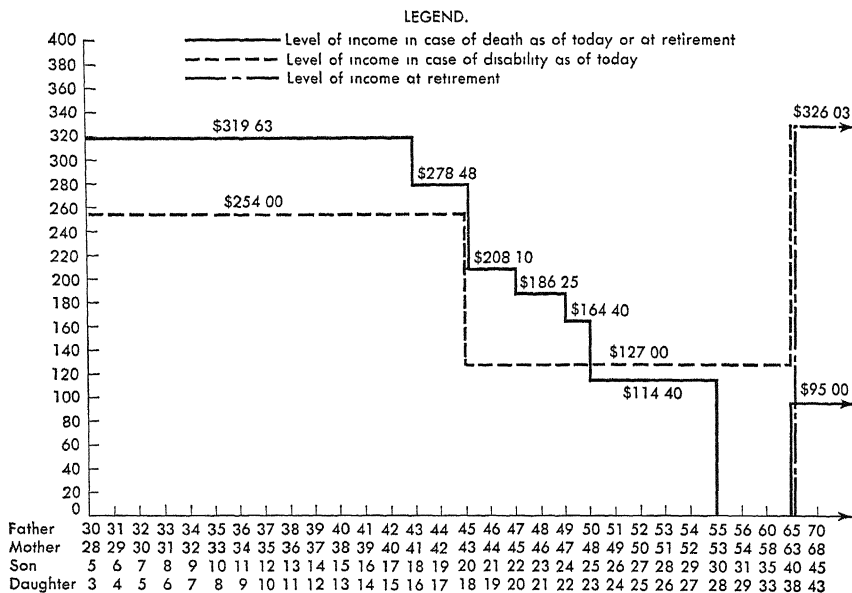
benefit, the amount will be \$64.)	52.60	
From company pension plan, which is set to bring father's benefit up to a total of \$250 a month (if it continues during disability)	123.00	
From cash values of life insurance (\$2,500 20-pay will have cash value at 65 of \$1,790; \$5,000 ordinary to which family income rider was attached, \$2,930, or \$4,720. Use \$840 to purchase \$1,162 of paid up life insurance for final expenses. The \$3,880 left will provide a ten-year and certain life income of)	23.43	
IN EVENT OF RETIREMENT OF FATHER (NON-DISABLED)—		
<i>In event of retirement of father (not disabled) when he is 65 and mother is 63</i>		\$ 326.03 mo.
From Social Security (combined husband and wife)	\$ 179 60	
From cash values of life insurance	23 43	
From company pension plan	123.00	
<i>In event of death of father after 65</i>		\$ 95.00 mo.
From Social Security for widow of retired worker	\$ 95.00	
<i>In event of death of mother either before or after father is 65</i>		\$ 273.43 mo.
From Social Security	\$ 127.00	
From pension plan	123.00	
From life insurance	23.43	

Analysis of Present Situation. The present program can probably be more easily studied if charted as shown on the next page. It will be seen at once that the income levels fall short of the "minimums" set by the family itself: \$350 a month until the children are grown and \$250 a month thereafter. The higher levels could be achieved in the earlier years, but it would be at the expense of the later years.

Under the program as set up, the highest income level is set during the years before the boy is 18 and, presumably, still in high school. The income drops when he starts to college although expenses will go up. However, he will be old enough to find some work to supplement the family income or to take himself partially off the family "payroll."

While much is said of the ever-increasing cost of college, the fact remains that the biggest cost of college is board and room away from home.

FINAL EXPENSES Father \$2,255 Mother \$592 Each child \$1,000	EMERGENCY FUND Whatever is left after final expenses	MORTGAGE FUND \$8,000 to pay off remain der due in case of death	MEDICAL CARE FUND Hospital \$20 a day each family member plus miscellaneous & surgical, 120 days
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This family, having no vocational ties to its home locality, can reduce the so-called college costs by moving to a college town where the boy can live at home. Moreover it may be able to find a small college town where living costs are lower.

The income drops again when the girl is 18 and ready for college. Again, however, she is now old enough to obtain some type of employment to help the situation.

After the girl has graduated, the incomes provided for the mother are highly marginal. With no children at home, she will be free to find outside employment, if she can at her age. If not, the children are now out of college and can help her.

It is certainly not to be argued that this is anything like an "ideal" program, but it does utilize the coverage available to what would seem to be to best advantage. There are weaknesses in the cash funds, too. Certainly the allowances for final expenses are marginal. As explained, the father's final expense fund allows only \$1,000 for expenses of final illness, and even though the present hospitalization policy might meet some of the expenses, provided he is hospitalized before death, the sum is not a really safe amount. If expenses are higher than \$1,000 plus whatever is paid by the hospital policy, funds will have to be drawn from other areas of the program, thus reducing

marginal incomes to sub-marginal. The mother's final expense fund might be enough for a funeral, but it leaves any last illness expenses to be paid out of the father's earnings. With the mother gone, his expenses would be increased by the necessity of hiring household help, and his taxes would go up since he no longer has the marital split. The final expense funds of the children are larger than that of the mother, but they, too, are marginal.

The mortgage fund is adequate to pay off the house if the father dies, but it provides absolutely no protection if he is disabled. Under the present program, if he is disabled before the mortgage is paid off, the family will have to try to keep up the installments with an income even further below the \$350 level than it will have in case of his death. The lack of any emergency fund—except what might be left over if the father's final expenses are not \$2,255—is dangerous in view of the marginal and sub-marginal status of the income levels. Finally, the medical-care fund is inadequate. First, it pays only in case of hospitalization. Second, the maximum for any one illness for any one family member is \$2,900 *provided* he or she is hospitalized a total of 120 days, draws the maximum miscellaneous allowance, and has the most expensive operation on the schedule.

Recommendations. As was stated, in programming, there can be almost as many valid recommendations as there are programmers on the case. The following recommendations represent one way the program might be strengthened. Other programmers would make other recommendations, but the effort here is to illustrate a process, not construct the perfect program. Those who have other ideas will develop programming skill by trying them out to show how they can improve on the suggestions here.

The first suggestion that might be made is to drop the present hospitalization policy. The medical care coverage it offers is limited by being available only if the insured is hospitalized and by the low maximum that could possibly be paid for any one period of hospitalization. It should be replaced with a Major Medical, which, while it does not pay for small medical care bills (which are more economically budgeted than insured anyway) it does offer benefits both in and out of hospital and has a high maximum. Recommended is a \$5,000 Major Medical with a \$250²³ deductible, \$20 a day board and room limit, no limit on surgery or nursing, and no co-insurance.²⁴ This policy is optionally renewable but carries a clause providing that renewal will not be denied solely on grounds of deterioration of health (which means non-renewal is confined to moral hazard). For the entire family, it will cost \$133

²³ This same policy is available with a \$500 deductible, but it is judged here that at its earned income level, \$500 in medical expenses for any one illness of any one family member might be a little difficult for the family to handle. Deciding whether to use a \$250, \$500, or even \$1,000 deductible is entirely dependent on the family's particular situation. The choice of \$250 here does not imply a blanket recommendation of that figure for each and every case.

²⁴ The "necessity" (or lack of it) of co-insurance from an underwriting standpoint can be and is being argued endlessly. Here we are not concerned with underwriting problems but only with the client's program.

a year. This is \$184.80 less than the annual premium for the present hospitalization policy and substantially better coverage.

With the Major Medical in force, the costs of final illness of any family member are now insured up to \$5,000. Therefore, the \$1,000 extra put in the father's final expense allotment can be taken out and used elsewhere; and the final expense allotments for the mother and each child become more sound. The amount they have in a lump sum from life insurance should meet their burial costs, and their final illness expenses are insured, the only sound way to handle them since the amount of them is unknown.

The Major Medical also improves the Emergency Fund situation. The \$1,000 can be put into the Emergency Fund and paid out in annual installments to meet the premium on the Major Medical if the father dies. In event of the death of the father, the premium on the Major Medical for the mother and two children will drop to \$89 a year. Paid out at the rate of \$89 a year, \$1,000 will last over 13 years, or almost until the children are grown. If payments on the Major Medical can be met from income during the earlier years when income is higher, the \$1,000 will make it possible to pay the premium until the children are grown, and perhaps longer for the widow.

The first recommendation changes a marginal Final Expense Fund into a satisfactory one, establishes an Emergency Fund where none existed, creates a better Medical-Care Fund—saves \$184.80 a year in premium money.

Perhaps the next recommendation should be to add mortgage disability insurance so the housing situation will be cared for in event the father can't work and, hence, can't earn the money to pay the mortgage installments. Recommended is a disability income policy in the amount of \$100 a month. The mortgage has 12 more years to run. Ideally, the policy should be \$100 a month payable for 12 years.²⁵ A 12-year benefit duration is not available (to the knowledge of the authors). The choice is, then, whether to gamble on a 10-year policy or to over-program by using a "to 65" benefit duration. In an actual case, with the faces of an actual family in front of him, this is a hard decision for the programmer to make. If he gambles on a 10-year policy, he saves a few dollars of premium money badly needed elsewhere in the program; yet if the father should become disabled within two years, the family might not be able to meet the last installments on the mortgage. It is decided to gamble and use a ten-year benefit policy on a non-cancelable, guaranteed premium form. This policy will cost \$63.90 a year with a 30 day elimination period.

With this coverage, the mortgage situation now stands thus: In event

²⁵ This is not quite correct. "Ideally," the policy should be one that pays for 12 years if the father is disabled today, 11 years if he is not disabled until next year, 10 years if he is not disabled until the year after that, etc. Such a policy is not now (at least to the knowledge of the authors) available. They predict its appearance as the practice of programming health insurance benefits creates a demand from agents for coverages more exactly suited to programming.

of death of the father, the remainder due will be paid off in a lump sum, leaving the house clear (but not "and free," as mortgage life insurance literature often insists; there will still be taxes, insurance, and upkeep). In case the father is disabled, the mortgage installments, which include taxes and insurance, will be paid by the new disability income insurance for each month (after the first) he is unable to work, up to the maturity of the mortgage.

Next, attention should be turned to the income levels.

The family has said it needs \$350 a month until the children are grown. (In the case of this family, that is interpreted, "until the children are 18." It might be desirable to have the \$350 until they are out of college; but premium dollars available will go only so far. Since a child of 18 is through high school and capable of working, he can add something to the family income thereafter—or relieve the family of some of the burden of his support—even if he works only part time while in college.)

An additional \$5,500 of life insurance paid out over 19 years until the daughter is 22 will add an additional \$30 a month to the present program. The cost for continuous premium, whole life (non-par or net after dividends and plus waiver of premium) will be \$90.20 a year.

The next recommendation is an additional \$4,500 of continuous premium whole life to be held at interest to the widow's age 43 (son 20; daughter 18) and then paid out at the rate of \$100 a month. During the interest-only period until the widow's age 43, it will pay about \$9.50 a month. If the company won't pay this small an installment, the money can be taken quarterly. From her age 43 to 47, it will pay \$100 a month.

This policy will cost (non-par or net after dividends and plus waiver of premium) about \$73.80 a year. The final life insurance addition recommended is \$5,000 term to 65, which is to be held at interest until the mother's age 47. During that time, it will produce about \$10.40 a month until she is 47 and \$33.20 from her age 47 to her age 62 (when a widow's Social Security old age benefits become payable). This policy, including waiver of premium, will cost \$65 a year.

The next area of recommendation is the disability picture. (It might even be argued that this area should have received the first recommendations inasmuch the incomes available under the present program for disability are even less adequate than the incomes in case of death.)

It will be recalled that the family said it could get along on \$350 a month until the children are grown and \$250 thereafter. The only disability income coverage available in the present program is that from Social Security, which will provide \$254 a month until the younger child is 18 and \$127 a month from then to age 65 (at which time the Social Security old age benefits take over, as previously described).

To fit the program exactly, it would be necessary to have a policy that will pay \$100 a month to age 45 and \$123 a month thereafter to 65. No such

policy exists—again, at least to the knowledge of the authors. The solution will have to be a compromise: a \$125 a month benefit policy with benefit duration to age 65. This will lift disability income during the years the children are growing up to \$379, slightly more than the family has said is the minimum; and the income after the children are grown to \$252, just about what they said is needed during that period. Such a policy, written in a non-cancelable form with a 30-day elimination period, will cost \$95.85.

The final disability recommendation is a readjustment policy. While no readjustment plan is suggested in case of death (as some programmers might in this type program), one is recommended in case of disability for two reasons—

(1) Social Security benefits do not start until the end of six months. The chance that the father will be disabled several times between ages 30 and 65 are much greater than that he will be disabled for six months or more. Short-term disabilities can be a serious financial problem not alleviated by Social Security ²⁶

(2) When a man is dead, his family knows his earning power is gone forever. When he is disabled, they may harbor the hope he'll return to work even though medical opinion is to the contrary. Therefore, the family of a disabled man will often continue spending at about its earned-income level until all reserves are gone.

A \$200-a-month disability income policy with a 30-day elimination period and one-year benefit duration will cost, non-can, \$47 a year. (This might make his total benefits exceed the underwriting limits of some companies for his income bracket, but not in all companies.)

The suggested program has now added the following premiums to those already in force in the family—

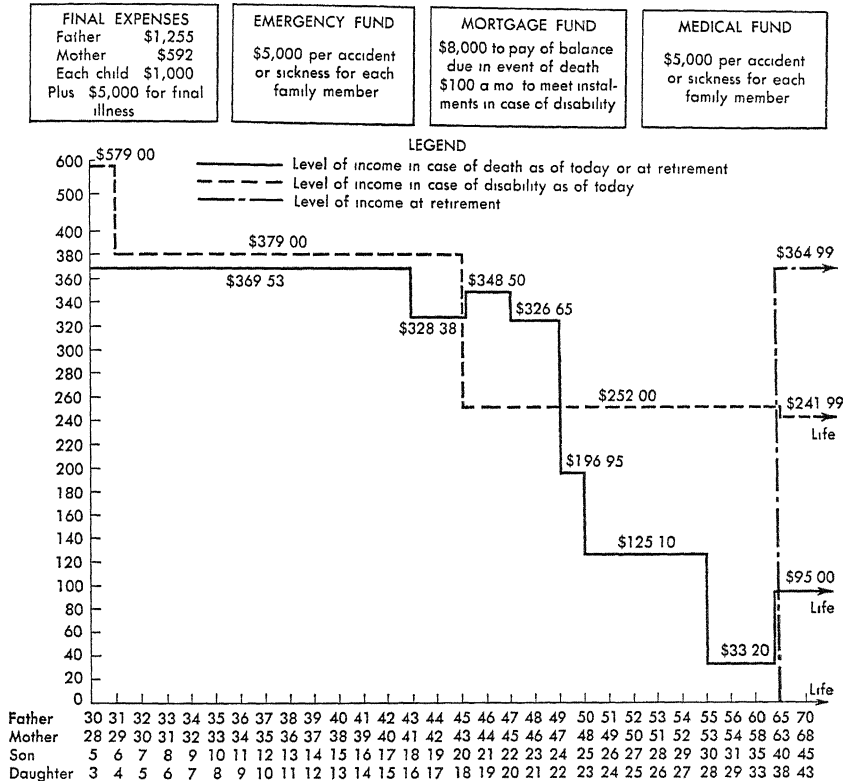
Mortgage disability policy	\$ 63.90
\$5,500 whole life	90.20
\$4,500 whole life	73.80
\$5,000 new term to 65	65.00
\$125 a month disability policy	95.85
\$200 a month, one year disability	47.00
TOTAL NEW PREMIUM	\$435.75
Savings effected by replacing present basic hospitalization policy with Major Medical	-184.80
NET ADDITION TO PREMIUMS	\$250.95

Inasmuch as the family has said it could put an additional \$20 a month into insurance premiums, the recommended additions to the program exceed the money available by \$10.95 a year. This can be handled in either

²⁶ Not alleviated by Social Security and not intended to be . . . Social Security was conceived of as a floor; therefore, it provides subsistence levels of benefits only. Whether Social Security can go beyond the "floor" concept and still leave the country with the type of economy we now have is beyond the scope of discussion of this text.

of two ways: (1) The family may agree that the new program is worth trying to save \$20.91 a month instead of the \$20 they set. (2) One of the non-can disability policies can be changed to guaranteed renewable.²⁷ For instance, the mortgage policy on a guaranteed renewable basis would cost \$51.10 a year, bringing total premiums down to \$238.15, \$1.85 *under* what the family said it could put into new premiums.

With the recommended additions to the present program, it now appears as in the following diagram.



In tabular style, the new program reads as follows—

Recommended Situation in Event of Disability or Death. This tabulation assumes, as has been said to be the only sound programming, that disability or death occurs as of tomorrow.

²⁷ Many programmers would recommend that all new health policies be purchased on a guaranteed renewable basis or even an optionally-renewable basis (renewable at the option of the company) in order to save premium money to bolster the death incomes. This is a matter of programming philosophy. As has been previously stated, the endeavor here is not to construct the "ideal" program beyond all criticism but to illustrate a process.

FINAL EXPENSES—

<i>In event of death of father</i>		\$6,255.00
From Social Security lump sum death benefit	\$ 255.00	
From the \$10,000 group life	1,000.00	
From Major Medical (up to)	5,000.00	
<i>In event of death of mother</i>		\$5,592.00
From Weekly Premium policy	\$ 592.00	
From Major Medical (up to)	5,000.00	
<i>In event of death of either child</i>		\$6,000
From E. 18's	\$1,000	
From Major Medical (up to)	5,000	

MORTGAGE

<i>In event of death of father</i>		\$8,000
From the \$10,000 group life	\$8,000	
<i>In event of disability of father</i>		\$100 mo.
From mortgage disability policy	\$100 mo.	

EMERGENCY FUND

<i>In event of death of father (up to)</i>		\$5,000
From Major Medical (up to)	\$5,000	

MEDICAL CARE COVERAGE—

<i>Medical expenses per family member (up to)</i>		\$5,000
From Major Medical (after \$250 deductible and up to \$5,000 any one disability)	\$5,000	

UNTIL SON IS 18—

<i>In event of death of father</i>		\$369.53 mo.
From Social Security	\$254.00 mo.	
From family income rider	50.00	
From proceeds of \$5,000 term to 65 and \$2,500 20-pay life held at 2½% under interest-only option	15.63	
From new \$5,500 whole life on 19-year installments	30.00	
From proceeds of new \$4,500 whole life, held at interest to son's age 18	9.50	
From proceeds of new \$5,000 term to 65, held at interest only to mother's age 47	10.40	
<i>In event of disability of father</i>		\$379.00 mo.
From Social Security	\$254.00 mo.	
From new non-can	125.00	

(Plus \$200 a month from new non-can, first year of disability at all ages below)

TO DAUGHTER'S AGE 18—

In case of death of father

\$328.38 mo.

From Social Security	\$191.00
From family income rider	50.00
From interest on term and 20-pay	15.63
From new \$5,500 whole life	30.00
From son's E. 18 paid out on four year installments	21.85
From new \$4,500 whole life at interest	9.50
From new \$5,000 term to 65	10.40

In event of disability of father

\$379.00 mo.

From new non-can	\$125.00
From Social Security	254.00

FROM DAUGHTER'S AGE 18 TO SON'S AGE 22—

In event of death of father

\$348.50 mo.

From Social Security	\$ 0
From family income rider	50.00
From proceeds of the term policy, paid principal and interest to exhaustion. (Will last approximately 5 years.)	91.90
From proceeds of 20-pay life, paid principal and interest to exhaustion. (Will last about 10 years.)	22.50
From E. 18's on both children	43.70
From new \$5,500 whole life	30.00
From new \$4,500 whole life paid out over four year period	100.00
From new \$5,000 term held at interest	10.40

In event of disability of father

\$252.00 mo.

From Social Security	\$127.00
From new non-can	125.00

FROM SON'S AGE 22 AND GRADUATION FROM COLLEGE TO DAUGHTER'S AGE 22—

In event of death of father

\$326.65 mo.

From family income rider	\$ 50.00
From proceeds of the term policy	91.90
From proceeds of 20-pay life	22.50
From daughter's E. 18	21.85

From new \$4,500 whole life	\$100.00	
From new \$5,500 whole life	30.00	
From interest on new term to 65	10.40	
<i>In event of disability of father</i>		\$252.00 mo.
From Social Security	\$127.00	
From new non-can	125.00	
FOR 1 YEAR AFTER DAUGHTER IS 22 (TO MOTHER'S AGE 48)—		
<i>In event of death of father</i>		\$196.95 mo.
From family income rider	\$ 50.00	
From proceeds of term policy	91.90	
From proceeds of 20-pay life policy	21.85	
From new \$5,000 term to 65, paid out on 15-year basis	33.20	
<i>In event of disability of father</i>		\$252.00 mo.
From Social Security	\$127.00	
From new non-can	125.00	
FROM MOTHER'S AGES 48 TO 53—		
<i>In event of death of father</i>		\$125.10 mo.
From proceeds of basic whole life policy to which family income rider was attached, paid out prin- cipal and interest to exhaustion. (Will last about 5 years.)	\$ 91.90	
From new \$5,000 term	\$ 33.20	
<i>In event of disability of father</i>		\$252.00 mo.
From Social Security	\$127.00	
From new non-can	125.00	
FROM MOTHER'S AGES 53 TO 62—		
<i>In event of death of father</i>		\$ 33.20 mo.
From new \$5,000 term	\$33.20	
<i>In event of disability of father</i>		\$252.00 mo.
From Social Security	\$127.00	
From new non-can	125.00	
FROM MOTHER'S AGE 62 TO 63—		
<i>In event of death of father</i>		\$ 95.00 mo.
From Social Security	\$ 95.00	
<i>In event of disability of father</i>		\$252.00 mo.
From Social Security	\$127.00	
From new non-can	125.00	
FROM MOTHER'S AGE 63—		
<i>In event of death of father</i>		\$ 95.00 mo.
From Social Security	\$ 95.00	
<i>In event of disability of father</i>		\$241.99 mo.
From his Social Security old age benefit (which is same as disabil-		

ity benefits he had been receiving up to age 65)	\$127.00	
From Social Security old age benefit for wife of worker who is 65 or over, when she is age 63. (If she waits until 65 to start her benefit, it will be \$64)	52 60	
From cash values of life insurance (20-pay, \$1,790; \$5,000 whole life to which family income rider was attached, \$2,930; from new \$5,500 whole life, \$3,080; from new \$4,500 whole life, \$2,520, a total of \$10,320, minus \$840 to purchase \$1,162 of paid up for final expenses)	62.39	
IN EVENT OF RETIREMENT OF FATHER (NON DISABLED)—		
<i>In event of retirement of father (not disabled) when he is 65 and mother is 63</i>		\$364.99 mo
From Social Security (combined husband and wife)	\$179.60	
From company pension plan	123.00	
From cash values of life insurance	62.39	
<i>In event of death of father after 65</i>		\$ 95.00 mo.
From Social Security	\$ 95.00	
<i>In event of death of mother either before or after father is 65</i>		\$273.43 mo
From Social Security	\$127.00	
From pension plan	123.00	
From cash values of life insurance	23.43	

Analysis of Recommended Situation. *Final Expense Fund:* This fund has now been greatly strengthened from the original situation. It contains what should be enough for the known final expenses plus up to \$5,000 for the expenses of final illness. There is no denying the fact that the amounts for known final expenses are small and that care will have to be exercised in such matters as the cost of the funeral; but the addition of the Major Medical policy makes the final expense picture much better.

Emergency Fund: With money in the Emergency Fund to pay the premium on the Major Medical in case of death of the father, the family is far better off than under the old plan. That plan provided an Emergency Fund amounting to only what might be left after final expenses. It should be remembered that "emergencies" can be of a nature other than accident or sickness. For instance, an emergency certainly exists for a family on

marginal incomes (such as are provided in this program) if the home heating plant has to be replaced or the house reroofed. If another \$1,000 or \$2,000 could be put in the Emergency Fund to be held at interest only with the right of withdrawal in whole or in part, the family would be better equipped for non-health emergencies. However, the only way to obtain money for the fund would be to take insurance proceeds now being used to maintain the income levels. Whether to keep the income levels a little higher or set up more in the Emergency Fund is something that has to be decided in the light of what the programmer knows about the ability of the family to handle money. If the family can budget carefully, it would seem better to keep the income levels up. Then, in case of a non-health emergency, the cost could be paid in installments. If the family can't budget, perhaps the Emergency Fund should be built up at the expense of the income levels.

Mortgage Fund: Whereas before there was no provision for handling the mortgage in case of disability, now the payments on it will be met to maturity.

Medical Fund: First-dollar coverage has been eliminated; but in its place, the family now has medical-care coverage both in and out of the hospital and has it in depth.

Family-Period Income: The family wanted \$350 a month "until the children are grown," which has been interpreted as "until they are 18." The new program supplies slightly more than \$350 in case of death until the boy is 18 and substantially more in case of disability. The "over-programming" involved in the disability income has been explained as necessitated by the lack of a policy exactly suitable to the need. However, it is true that in case of disability, living costs will be higher than in case of death. For just one thing, in case of disability, there is one more mouth to feed.

College Period. Here, again, as in the original program, income drops during the college years; however, it is substantially more than it was in the original program, making the possibility of the boy and girl working part of their way through college even more feasible. In case of disability, the income drops even more, but is twice what it was under the old program and is in the amount the family said it could get by on after the children are grown.

College to Retirement. In case of death, the widow has at least *some* income. Certainly between 55 and 62, it is not a livable income; but by then the children will be able to help her, and the small income she has will at least keep her from feeling she is a complete burden. Probably the next in this program, as soon as the family has more money available for premiums, is to increase the incomes available to the widow between her ages 48 and 62. In case of disability, this period is covered for the \$250 a month the family said it could get along on after the children are grown.

If the father should become disabled for a period of time and then die, the disability income would of course, terminate; but the life insurance kept in force with waiver of premium would then be available to use for income.

Retirement: The retirement picture for husband and wife together is

good if the father retires non-disabled. If he is disabled before retirement, it is slightly below the minimum income they said they'd need. If he predeceased the mother, the retirement income picture for her is *not* good. Perhaps this might be the second area to consider as soon as the family has more premium money.

One more recommendation might be made in this program, but it is one many agents would hesitate to make because of the possibility that their motive might be misunderstood: In this tight a program, the E. 18's on the children are taking a disproportionate amount of premium money. It would probably be better if these were converted to continuous-premium, whole life policies (for final expenses) and the premium saving used to buy more life insurance on the father to help out with the income levels during the low period between the time the children are grown and the widow is 62.

The 20-pay life policy on the father might also be criticised as consuming too much premium for this tight a program. For the premium he is now paying for \$2,500 of 20-pay, the father could have \$3,600 of continuous-premium whole life. Again, the agent who suggests such conversion might be criticised as a "twister."²⁸

The recommended program is not intended to be a "model" program. As was stated, for any given set of facts, there can well be as many recommendations as there are programmers working on the case. However, the effort here has been to illustrate the process of integrated programming of life and health insurance.

4. SUMMARY OF PROGRAMMING.

Insurance needs are as individual as are people. It is no more possible to set up one formula by which everyone can determine how much insurance he should have than it is to offer one medicine for every illness. The only way to determine how much insurance is needed in a given case is to analyse all the facets of it, including the family's attitude toward money and money management. The process of analysing needs and fitting policies to them is the process known as "programming."

Needs in Programming. The process of programming consists of several steps, the first of which is the needs analysis. While needs vary with individuals and the order of their importance varies with the family situation and philosophy, the following basic needs appear in almost every program in about the order of importance listed here—

1. Cash needs for final expenses, outstanding debts, unpaid taxes
2. Mortgage coverage to pay off (or reduce) the mortgage in case of death and to meet the payments in case of disability
3. Readjustment income to give the family a "breathing spell" before it must reduce its standard of living

²⁸ He lessens the chance somewhat if he effects the conversion within the company that issued the policies.

4. Family period income during the years the children are growing up
5. Income after the children are grown and until retirement benefits start
6. A college education fund
7. Wife insurance to offset the extra costs that will come if the mother is taken out of the home. (This need exists in the case of the disability as well as death of the mother; but coverage for disability is rarely available.)
8. Retirement income

In addition to these basic needs, a number of others might be listed. Most of them, however, are less than basic. While they are valid if there is enough premium money left over after taking care of basic needs, almost always, they should be the very last needs (or "wants") to be considered.

The Tools of Programming. The tools of programming are the policy settlement options, the most common of which are *interest only*; *fixed-period income*, under which the proceeds are paid out over a specified period of time; *specified amount* (sometimes called "principal and interest to exhaustion"), under which the proceeds are taken in a selected dollar amount per month for as long as the money and interest earned on the unpaid portion last; *life income*, the annuity option, under which the proceeds are paid at the rate of so much per month per \$1,000 of proceeds (the amount varying by age and sex) as long as the policyholder lives. In a variation of life income, the annuity is paid during the lives of either of two annuitants. This option is known as *joint and survivor*.

The Process of Programming. The process of programming consists, *first* of determining needs and their order of importance in a given case; *second*, of determining how much income should be provided to cover those needs; *third*, how far present coverages and any other income-producing assets owned will go toward providing the amounts needed; *fourth*, determining what gaps exist between needs and coverages presently available; *fifth*, making recommendations for new coverage to fill the gaps; and, *finally*, selecting and putting into effect all settlement options and other policy safe-guards required by the program, such as (1) proper designation of primary and contingent beneficiaries; (2) spendthrift clauses (where desirable and permissible); (3) proper selection of settlement options; (4) proper selection of dividend options (if a participating plan); (5) common disaster clauses; (6) premiums arranged to avoid extra charge for greater than annual frequency of payments; (7) inclusion of automatic premium loan (when allowed by company); (8) disability protection where available; (9) hedging of policy loans; (10) wise use of deductibles and elimination periods in health coverages.

Life and health policies are the raw materials with which to build a house of protection. The process of building that house is "programming."

QUESTIONS FOR CLASS DISCUSSION

- 1 Several formulae have been suggested from time to time to help a man determine how much income insurance he should own. Explain why you think such formulae might or might not be accurate for a given family
2. Which is more important adequate life or adequate health insurance? Discuss.
- 3 Assume that the money available for premiums is insufficient to cover *all* needs adequately As a programmer, would you cover all needs to some extent or the more important needs in full, leaving some needs completely uncovered? Explain your reason for your answer.
- 4 The Macmillan family, composed of a father 35, mother 31, George 5, and Caroline 3, budgets \$500 a year for income insurance Suggest a program for this family that will make best use of the \$500 Make whatever other assumptions you care to about other assets owned by the family.
5. Suppose the family could spend twice as much for insurance as indicated above What would your program recommendations then be?
- 6 Suppose the family could spend only half as much as in question 4 What would your recommendations be?
7. Develop the kind of program you feel you need for yourself How much would it cost? If you cannot afford your "ideal" program (and few people can), where will you cut it and why?
8. Explain the importance of selecting the correct dividend option in programming income insurance.
- 9 Aside from selecting policies and assigning them to various needs, what would you say is the job of a programmer?
10. In what ways would you handle the program developed in this chapter differently from the ways the authors handled it—and why?

CHAPTER 17

Insurance in Estate Planning

As the term is commonly used, "estate planning" includes not only estate conservation but also estate creation. Thus, the matters discussed in Chapters 15 and 16 actually are a part of estate planning in the broad sense. The term may be used also in a restricted sense to mean the protection of an existing estate by developing plans for the disposition of the estate that give the maximum benefit to the recipient. Included in the role of estate planning is the prudent use of estate assets during the lifetime of the estate owner by utilizing arrangements which are not in conflict with his aims and philosophy.

Many persons with substantial estates do not recognize the need for estate planning and fail to appreciate the role that life insurance can play in its development. These persons are confident that should they die, even prematurely, their assets will adequately take care of their dependents. They overlook the fact that costs and taxes connected with death may greatly reduce the size of the estate and the amount of the income resulting from it. Possible changes in the economic cycle are ignored. A financial or estate plan may be necessary to protect the estate from depletion. Estate planning, however, should not be confined to the large estate. It can be useful for the small estate also.

Estate planning in the narrow sense has three fundamental objectives: (1) reduction of the cost of transfer, (2) arrangement for the most economical method of paying transfer costs which cannot be eliminated, and (3) development of changes in the character of estate property so as to make wiser use of assets. Many techniques have been developed to achieve these objectives. Life insurance plays a vital role in a number of these techniques. The life underwriter, together with the lawyer, who co-ordinates all activities and prepares the necessary legal documents; the accountant, who gathers much of the needed information; and the trust officer, who is prepared to provide expert fiduciary services where needed—all these make up the estate planning team. Each expert provides the service of his field.

It is the purpose of this chapter to describe the role of the life underwriter as a member of the estate planning team and to show how life insurance may be used to protect estates. The tax aspects of life insurance policies also are a subject of this chapter.

1. THE ROLE OF THE AGENT IN ESTATE PLANNING.

Why has the life insurance agent become a member of the estate planning team? Why has he joined the field of the experts such as accountants, lawyers, tax consultants, and trust officers? A number of reasons justify the presence of the life underwriter.

Life Underwriters as Advisors in Personal Finance. For years, life insurance men have undertaken the responsibility of motivating men to save. They have helped and encouraged men to create estates. It is only logical that they should help men conserve and protect their estates once they have been accumulated.

Life Underwriters Are Experts in Motivation. It is always the other person who is going to die. Just as a man must be motivated to protect his earned income against premature death, so also he must be persuaded to protect his estate against postdeath shrinkage.

The canons of ethics of the American Bar Association prevent an attorney from going to his clients. Instead, he must wait for the clients to approach him. Similarly, accountants abide by the code of ethics prescribed by the American Institute of Accountants. Both the legal and accounting professions feel, therefore, that it is not in good grace to communicate with clients and make suggestions regarding the clients' affairs, particularly with reference to their estate.

On the other hand, life underwriters can and are expected to be aggressive. It is proper for them to bring up the subject of estates and to urge that action be taken to put them in order. The life insurance agent fills a gap between counsel and client. He is often the moving force behind the creation of the plan.

Estate Planning Means More Insurance Sales. Life insurance may be used in many ways in meeting the three major objectives of estate planning. It may be used to reduce the cost of estate transfer. In most cases it may also be used to provide the most economical method of meeting estate settlement costs. And life insurance is treated favorably under the income tax laws. How life insurance can be used in estate planning will be seen presently.

A working knowledge of estate planning can, and does, lead the underwriter to the ideal type of prospect. He calls on and talks with men of substantial means. He is able to help them distribute their assets in the most advisable way. He helps them arrange their estates to eliminate the probability that assets will have to be sacrificed at forced sale to raise the cash necessary to pay the costs of estate transfer.

All Life Insurance Men Are Not Qualified to Assist in Estate Planning. Estate planning has many facets. It requires knowledge of the law of wills, trusts, and taxation—to name a few. Taxation problems are further divided into estate tax, gift tax, inheritance tax, and income tax problems. The in-

insurance man who attempts to join the estate planning team must be familiar with these concepts in addition to being a real expert in life insurance.

2. THE COSTS OF ESTATE TRANSFER.

Estates shrink as they pass from one individual to another. Several factors are responsible.

Administration Cost. All property does not pass directly from a decedent to his heirs or beneficiaries. Real estate descends to the heirs or devisees under the will, but personal property is collected by the personal representative (executor or administrator) ¹ and, after the payment of all debts, taxes, and costs of administration, is distributed to the next of kin or legatees under the will. The administration of estates costs money. So much has to be done which involves expense. The will has to be filed, property has to be appraised, tax returns have to be prepared—and all these transactions involve the services of lawyers, accountants, appraisers, and others.

Estimates have been made on the cost of estate administration. On the average they run between 4 per cent and 5 per cent of the size of the estate. For an estate of \$50,000, the estimated cost would be approximately \$2,300, whereas the estimated cost would be \$6,900 for an estate of \$150,000. On estates of \$500,000, the estimated administration cost is about \$22,500, and for a \$1,000,000 estate it is \$43,000. These are, at best, rough estimates. Obviously, they will vary widely from case to case depending upon the character of the estate property, the complexity of the estate distribution plan, the number of states in which property is located, and whether or not the will is contested. At any rate, administration cost is an important item of estate shrinkage.

Debts. Before estates may be passed to heirs, all debts must be paid. Since most people use credit facilities, there are usually debts to be paid out of the estate. The size of the debt will vary with the size of the estate, the length of the last illness, and the habits of the deceased.

Taxes. One of the major causes of shrinkage in the transfer of estates is taxes, which cut deeper than most people realize. Death taxes are levied by both the federal and state governments and are of two types: (1) an estate tax, which is a tax on the right to transfer property at death and is measured by and collected from the estate, and (2) an inheritance tax, which is a tax on the right of the beneficiaries to receive property and is collected from them. The federal death tax is an estate tax. Commonly, the owner of a modest estate thinks of the federal estate tax, at least, as being the problem of the millionaire. Yet if a man owns a home, a car, a reasonable amount of life insurance, and has a few investments here and there, estate taxes begin to be a problem. Anyone who will leave more than \$60,000 after deductions

¹ The executor is appointed to execute a will; the administrator is appointed by the court to administer an estate when there is no will or where no one was designated in the will as executor.

for administration expenses, funeral costs, and debts faces an estate tax problem; and while it may be possible to arrange the \$60,000 estate so that the problem is eliminated, the owner needs to go into the matter thoroughly.

In addition to the federal estate tax, state death taxes must be taken into consideration in estate plans. States impose one or all of three of the following types of taxes. (1) an inheritance tax, (2) an estate tax, and (3) a credit estate tax that can be used as an offset to the federal tax. The first is imposed on and measured by the shares received by the individual beneficiaries. The second, like the federal tax, is imposed on and measured by the estate before it is broken down into shares. The third is a type of tax levied where the regular state death taxes produce less than the maximum credit allowed for state death taxes under the federal law. Its purpose is to bring the state levy up to this maximum.² Only the state of Nevada imposes no death taxes whatsoever; and while rates in most of the states are low in comparison to federal estate tax rates, the exemptions even to Class A³ beneficiaries are as low as \$5,000 in some jurisdictions.⁴

Still other taxes can cause estate shrinkage (1) accrued federal income taxes in the case of a person whose income is not wholly subject to withholding and in the case of a person for whose salary the withholdings are insufficient; (2) accrued state income taxes, these usually not being collected by payroll withholdings; (3) accrued personal and real property taxes.

Other Factors Causing Shrinkage. Two other factors cause shrinkage in an estate which contains general property holdings: (1) the loss of the superior investment management ability of the estate owner and (2) the necessity of a changed philosophy of investment when the estate owner dies.

(1) When an estate passes from the owner through the executor or administrator to heirs or legatees, it loses the benefit of the management of the original owner, whose knowledge of the peculiarities of the estate and whose management skill, particularly in the case of the estate containing business interests, may have been the major factor in making it profitable

(2) The beneficiary of an estate is interested primarily in income, not

² Four states (Alabama, Arkansas, Florida, and Georgia) have only the credit estate tax. Only Nevada, Mississippi, North Dakota, Oregon, Utah, South Dakota, and West Virginia do not have this tax. Thus, in most states, the maximum credit for state death taxes is taken. No credit is allowed on taxable estates not exceeding \$40,000. For a taxable estate of \$40,000 to \$90,000, the maximum credit is 0.8 per cent of the amount in excess of \$40,000. For taxable estates from \$90,000 to \$140,000 the maximum credit is \$400 plus 1.6 per cent of the amount in excess of \$90,000. A table of maximum credits is published in the Internal Revenue Code, and these credits progress upward to \$1,082,800 plus 16 per cent on the amount in excess of \$10,040,000.

³ Usually the surviving spouse, children and grandchildren, parents, and grandparents. However, the definition varies from state to state, in some few instances including only the surviving spouse.

⁴ District of Columbia, Hawaii, Louisiana, New Jersey, Ohio, and Virginia, for example. For a good digest of state death taxes see the *Advanced Underwriting and Estate Planning Service*, Vol. 1, Section 3, pages 19-66, of the Research and Review Service, Indianapolis.

capital appreciation, as the estate owner may have been; consequently, estate property that is ideal for an active businessman may not be ideal for a widow. Few businessmen, if possessed of foresight enabling them to know they would die within a year, would leave the character of their estate unaltered. Such changes, made by the executor or the beneficiaries, often involve loss which must be offset with life insurance if the estate value is to be preserved. Actually, the executor may be limited by law as to the types of investments he can retain, unless the will gives him discretion.

3. THE PROBLEM OF ESTATE LIQUIDITY.

The major problem of estate protection is that of offsetting the shrinkage factors in estate transfer.

The Necessity of Planning for Shrinkage. The costs of estate transfer must be paid in cash in relatively short order. Usually, debts, administration expenses, and state death taxes have to be paid within a year. Federal estate taxes must be paid within fifteen months after death or they incur interest costs and, in some cases, special penalties. Estates, therefore, should contain sufficient liquidity to meet these costs, or a forced sale of preferred estate assets, which will raise cash more readily, might be necessary.⁵

Forced liquidation often results in heavy losses to the estate. The amount of the losses, if any, depends upon two factors: (1) economic conditions at the time of the forced sale and (2) the nature of estate assets.

Economic Conditions. If death comes in a period of prosperity, the problem of forced liquidation of estate assets may not be difficult. At such times, market prices for most estate property are not depressed, assuring adequate liquidation values for the major portion of estate property. Periods of prosperity, however, do not assure that *all* estate assets can be marketed without a sacrifice, for there may be some for which the market is down in spite of general prosperity. Furthermore, in a forced sale situation, there is an inequality of bargaining power between the buyer and seller with the seller frequently getting the short end of the deal.

If death comes in a period of depression, the forced liquidation problem becomes a major one. Trust officers of banks can recall many estates with a high proportion of nonliquid holdings which were reduced to a small fraction of their former worth because of the necessity of a forced sale to raise money to pay estate settlement costs. No one knows what the economic conditions will be at his death; therefore, he must be prepared for the worst.

The Nature of the Estate. A liquid asset is one which can be converted

⁵ Usually the income produced by the estate is insufficient to pay the estate transfer costs and provide an adequate income for the dependent survivors. A loan is not generally a feasible solution to the problem since the executor usually does not have the authority to borrow money for the estate. Therefore, should he borrow on behalf of the estate, he would be personally liable. Even where the executor has authority by will to borrow money, a loan is not an adequate solution; the loan may not be easy to arrange, and the interest cost may be as expensive as liquidation losses.

into cash on a moment's notice and without loss of value. Accordingly, cash is the most liquid of all assets. Aside from life insurance, government bonds and widely circulated stocks⁶ are perhaps the most liquid of earning assets. If estates were made up in a large part of highly liquid assets, the problem of forced liquidation would not be serious. Liquidity, however, costs money. As a general rule, liquid assets produce a lower rate of return than nonliquid assets. Many estate owners are reluctant to sacrifice yield for liquidity.

Advance Planning. To avoid forced liquidation, advance estate planning is necessary. It is strange how few people plan their estates to avoid forced liquidation; too few people really understand what forced liquidation means. Forced liquidation does not mean that the less desirable assets of the estate will be liquidated, leaving the more desirable ones for the heirs. It means that the best part of the estate will be sold—the safest and most liquid investments are used to meet the costs of estate transfer.⁷

The Small Estate. The necessity for advance planning is not confined to the large estate. Estate planning may also be important in the relatively small estate, even though death taxes are not a significant consideration. Cash will be needed to meet estate administration costs, to retire debts, and to pay accumulated income and property taxes. The relatively small estate is just as apt to be without sufficient cash as is the large estate. Liquidation losses are likely to be felt more acutely by the beneficiaries of a small estate because the amount to begin with is small and the losses could reduce the standard of living of the survivors to the subsistence level.

4. HANDLING ESTATE TRANSFER COSTS.

If an estate owner wants to prevent the forced liquidation of estate assets to meet estate transfer costs, he must arrange in advance for the necessary estate liquidity.

One method would be to keep on hand a large cash fund. Obviously, this method is uneconomical. There is no reason to hold idle cash to pay expenses which have an uncertain due date if insurance can be arranged for the uncertainty.

The Use of Life Insurance. The most logical method of meeting estate obligations is through life insurance. Under a life insurance plan, the same contingency (death) which creates the estate liability will create an offsetting estate asset. Furthermore, the value of the life insurance at death, when the cash is needed, is greater than it will ever be during the life of the insured. An earning asset which has a higher "death-liquidated value" than living "going-concern value" is especially useful in estate planning. The use of

⁶ Where one individual owns a large block of stock in one company, the entire block may not be as liquid as a few shares, since an effort to sell a large block of stock may depress the market for that stock.

⁷ Cases are on record in which families have lost control of a business because of the necessity for forced liquidation of a portion of stock to pay estate transfer costs.

life insurance to pay estate settlement costs allows the current estate to be passed intact to the heirs and legatees.

Not only does the use of life insurance to pay estate obligations avoid liquidation losses in estate settlement, but it also reduces the cost of estate transfer. It makes it practical for the insured to maintain a less liquid but higher-income-producing estate. It lessens the problems of estate settlement, thus reducing the cost of administration. The immediate cash provided by the insurance enables the executors to take advantage of all cash discounts for prompt payment. Finally, it is the least expensive way of providing estate liquidity, for it enables the insured to pay his estate liabilities with "fractional" dollars. For example:

With nonparticipating single-premium life insurance, a man aged 50 can pay a \$10,000 estate clearance bill for just a little more than 60 cents on the dollar by purchasing a \$10,000 single-premium whole life policy for a \$6,000 premium. If the insured is aged 40, little more than 50 cents on the dollar will pay the bill. At age 60 it will take a little more than 70 cents on the dollar. If he uses a nonparticipating twenty-pay life policy, his premium at age 50 will be about \$472 a year to offset the \$10,000 estate clearance bill. The total cost of his tax bill will then depend on how long he lives. It cannot exceed \$9,440 for the \$10,000, which means he will never have to put up 100 cents on the dollar to pay the clearance bill. On a non-par continuous-premium whole life form, the annual cost at age 50 would be about \$370 a year. The insured would have to live to be age 78 before he would have paid more than 100 cents on the dollar for his estate settlement cost.

Therefore, it would seem worth while to consider transferring part of the estate assets to single-premium life insurance or using part of the income to buy annual premium life insurance. It is true that the above estimates of savings on the tax bill do not take into account the income these assets were earning before being transferred to single-premium life insurance, or the income the money put into annual-premium life insurance could earn if invested in other securities. However, if the individual is in high income tax brackets, his investment income will be subject to high tax rates, and the net income foregone by putting the money into life insurance will not be significant.

One problem, however, relating to the use of insurance to meet death costs merits careful consideration. If the insurance dollars are considered a part of the estate, they will increase the estate tax bill. Therefore, if the insurance proceeds are taxed in his estate, a man aged 50 who buys single-premium life insurance for 60 cents on the dollar will find that, at his death, the additional 40 cents will be taxed at the highest estate tax rate applying to that estate, perhaps 50 per cent in a very large estate. The net result is a gain of only 20 cents on the dollar.

In the small estate the death tax problem is not an important consideration. In the large estate, however, the tax problem is one which must be given

serious attention. Life insurance purchased to pay death taxes can be arranged so as to keep the insurance out of the estate of the deceased. Under present tax laws, in order to prevent the insurance proceeds from becoming subject to estate tax liabilities in the estate of the insured, the insured must not have any incidents of ownership in the policy. Incidents of ownership include the right to the cash values and proceeds, the right to change the beneficiary, the right of assignment, and the like. If the insured has any such right, either alone or acting with someone else, the proceeds will be taxable in his estate. Under the law as of this writing, it does not matter who pays the premium on the policy. The insured may pay it himself, and proceeds still will not be taxable in his estate if the beneficiary has ownership of the policy with no more than a 5 per cent chance of reversion to the insured.

Arranging Insurance for Estate Liabilities. The type of life insurance policy which should be used for estate protection purposes depends upon the nature of the estate. In large estates where income is taxed in high brackets, there may be a tax advantage in buying single-premium life insurance to meet estate obligations. The annual interest and survivorship increments to the cash value under the single-premium (as well as annual-premium) policy accrue tax-free.

Where the estate is invested in the controlling shares of a business, it may not be desirable to liquidate any of these shares to buy single-premium life insurance. The best plan may be to use part of the income from these assets to pay premiums for annual-premium life insurance. The same may be true of other assets which the estate owner may wish to hold.

The amount of life insurance needed would depend upon an estimate of (1) the costs of estate transfer and (2) the loss of income, if any, resulting from the change in estate management. These factors are not easily measured. They must be estimated. Trained life insurance agents often are able to estimate these costs within a reasonable margin of error on the basis of past experience.

Other things being equal, the executor of the estate should be the beneficiary of the policy, since he will have to pay all estate transfer costs. However, other things usually are not equal, as the following discussion will show.

The Smaller Estates. In the relatively small estates there may be some advantages in naming the widow as a revocable beneficiary. Life insurance proceeds paid to a named beneficiary are not subject to state death taxes in a number of states.⁸ Moreover, proceeds paid to a named beneficiary do not go

⁸ In all but nineteen states, life insurance paid to a named beneficiary is exempt from state death taxes even if the insured retained an incident of ownership. In fourteen of these nineteen states, special exemptions varying from \$10,000 to \$75,000 are granted for proceeds paid to named beneficiaries. Four of the five states not providing exemptions impose only a credit estate tax, so no state death taxes need to be paid unless there is a federal tax. The fifth state, Arizona, has an estate tax with tax brackets equal to the maximum state death tax credit allowed under Section 2011(b) of the Internal Revenue Code. It has no inheritance tax.

through the general estate for probate; so certain probate expenses will be saved. The disadvantage of naming the widow as revocable beneficiary is the lack of assurance that she will use the funds to pay the estate liabilities. This, of course, might be an advantage if it were to prove more attractive to retain the insurance proceeds than to preserve the general estate.

If the insured wants to make sure that the policy proceeds will be used on behalf of the estate and, for the reasons given, does not want to name his estate as beneficiary, he may use a revocable life insurance trust. The trustee is named beneficiary of the policy and is authorized to purchase assets from the general estate (or to make loans to it) in amounts necessary to pay off the estate liabilities. The executor is given the authority to sell to or borrow from the trustee by the insured in his will. The disadvantage of this arrangement is the added cost involved in the creation and administration of the trust.

The Larger Estates. In the larger estates none of the above beneficiary arrangements may be satisfactory. Life insurance payable to the estate or to revocable beneficiaries (individuals or trustees) is taxable under the federal estate tax laws. A beneficiary arrangement which will exclude the life insurance proceeds from the estate of the insured may be desirable. One such arrangement is for the proceeds to be payable to an owner-beneficiary with someone other than the insured being designated as successor-owner in the event of prior death of the beneficiary-owner. As mentioned earlier, although the insured may pay the premiums, he must have no incidents of ownership in the policy. The disadvantages of this arrangement are the same as the revocable beneficiary designation plus the fact that the owner-beneficiary can cash in the policy before the insured dies. Also, if she predeceases the insured, the value of the policy will be includible in her taxable estate.

If the insured has adult children, a better plan might be to have one or more of them owner-beneficiaries of the policy. This will also ease the tax problem in the wife's estate, since the policy will not be taxable in her estate if she predeceases her husband. Furthermore, if she outlives her husband, the insurance proceeds will not increase her estate and thus raise her potential estate tax liability. The children can use the proceeds to buy estate property and thereby give the necessary liquidity to the estate.

In order to guarantee that the policy proceeds will be used to provide estate liquidity, the insured can create an irrevocable trust to own and be the beneficiary of the insurance. The trust agreement can authorize the trustee to purchase estate assets from the executor or to lend the executor cash to provide the necessary estate liquidity. The insured's will can give to the executor the authority to sell to or borrow from the trustee. If the trust beneficiary has only a life interest in the trust income (i.e., no right to terminate the trust and take over the property), the trust property will not be taxable in the beneficiary's estate.

If the plan is designed to free the insured's estate of the insurance pro-

ceeds, the owner-beneficiaries must not be under any *legal* obligation to use the policy proceeds on behalf of the estate. Otherwise they will be taxable in the insured's estate. Also, if the insured pays the premiums on the insurance, these premiums will constitute a gift, which may be subject to the gift tax to be discussed later.

The policy proceeds should be placed on the interest-only option with full right of withdrawal. In this way the proceeds can earn interest until the funds are needed.

5. REDUCING ESTATE TRANSFER COSTS.

Estate planning involves not only providing estate liquidity to pay the cost of estate transfer but also arranging the estate to reduce these costs. In the small estate the principal objective is to save administration costs, whereas in the large estate the major concern is to reduce the tax liability.

The principal method of effecting savings in estate administration costs is to arrange for the property to be transferred to the beneficiary without its having to be probated.⁹ The purpose is to bypass probate and other administration costs, and to eliminate the risk of having the estate owner's distribution plan contested by disappointed actual or "would-be" heirs. The costs and delays involved in defending against a contested will can be expensive.

To save federal estate taxes, a properly drawn will and the use of other transfer devices can be effective. These estate transfer devices—life insurance paid to a named beneficiary, wills, gifts, trusts, and joint ownership—need examination.

Life Insurance Payable to a Named Beneficiary. Life insurance should usually be made payable to a named beneficiary rather than to the insured's estate. A named beneficiary, it will be recalled, saves probate costs because the proceeds will be paid directly to the beneficiary rather than first passing through the estate. Furthermore, as previously mentioned, the use of a named beneficiary will exempt the insurance proceeds in whole or in part from death taxes in virtually every state. Federal estate taxes, of course, are unaffected by the naming of the beneficiary unless the insured has given up all incidents of ownership.¹⁰ Another advantage of paying policies to a named beneficiary rather than to the estate is the speed of settlement. Estates take time to settle, but life insurance proceeds are paid without delay.

The advantages of life insurance as estate property make it a candidate for consideration in lieu of other estate property currently held by the estate owner. It might prove beneficial to convert certain estate property into single-

⁹ To probate means to establish the authenticity or validity of a will. This is done in a probate court, a special court limited to the administration of decedent estates.

¹⁰ I.R.C., Section 2042, includes as an incident of ownership any reversionary interest in the policy (either by law or contract) that exceeds 5 per cent of the value of the policy immediately before the death of the insured. The reverter interest is valued actuarially and is based upon the probability of the insured surviving the beneficiaries.

premium life insurance or to use the income from the estate to buy annual-premium insurance to utilize the investment advantages of life insurance¹¹

Wills. Upon a person's death, his property may be distributed either under the laws of descent and distribution¹² or by will. The laws of descent and distribution are state laws prescribing how property is to be allocated in the absence of a will.¹³ Unless a person wants his property distributed in accordance with the "public will" made by his state legislature, he had better make his own will. Although he does not have complete freedom in making his will,¹⁴ he can design one more in keeping with his objectives than the one written for him by the state.

Through a will, the testator¹⁵ can discriminate among his children, leaving the largest shares to the ones that deserve (or need) them the most. If the estate is small, the testator may not wish to divide the estate but to leave it entirely to his wife to provide her with a livable income. The testator may wish to include persons not covered by the laws of descent and distribution, or to leave specific property to certain designated individuals rather than to leave them shares in the net estate. Another advantage of a will is that it allows the testator to select his own executor.

The Marital Deduction. In the case of an estate passing between husband and wife by reason of death, a "marital deduction" is allowed by Section 2056 of the Code. The marital deduction has important applications in estate planning. In some situations it will be impossible for the estate owner to take full advantage of the marital deduction without executing a will. In estate planning, it is highly important that this deduction be clearly understood. The marital deduction is whatever the deceased leaves his surviving spouse outright or under a nonterminable interest,¹⁶ up to 50 per cent of the

¹¹ Cf. Chapter 7 for a discussion of the investment attributes of life insurance.

¹² Laws of descent specify how real estate passes to heirs, whereas laws of distribution indicate the method of disposing of personal property.

¹³ The Illinois law, for example, provides that one-third of each parcel of real estate and of personal property goes to the surviving spouse, and two-thirds to the children equally, or their issue *per stirpes* (one from whom a family is descended). If there is no surviving spouse, real and personal property goes to all the children equally, or their issues *per stirpes*. If there are no children, one-half of the real estate and all of the personal property goes to the surviving spouse, and the other one-half of the real estate is shared by the parents, brothers, and sisters equally. If there is only one parent, he or she receives two shares, and if there are deceased brothers and sisters, their issues share *per stirpes*. If there are no children or spouse, the parents, brothers, and sisters share equally. Where the decedent leaves no heirs, his property passes to the state under the escheat statutes. *The statutes vary among the states*.

¹⁴ The rights of the surviving spouse usually are protected by state law, and some states restrict the amount of charitable contributions. Rules against perpetuities and accumulation of income also restrict the testator.

¹⁵ The person who makes a will.

¹⁶ A terminable interest is one in which the spouse's interest in the proceeds is for life only, or one that will terminate or fail upon the lapse of time or the occurrence or nonoccurrence of an event or contingency; provided an interest passes or has passed to someone other than the surviving spouse or his or her estate, and such other person may possess or enjoy the proceeds after the interest of the surviving spouse fails. I.R.C., Section 2056(b)(6).

adjusted gross estate.¹⁷ Inasmuch as the portion of the estate qualifying for the marital deduction is not subject to estate tax, use of it can effect material savings.

Assume a married man is worth \$220,000, including securities, cash, business interests, real estate, life insurance, and all other assets. When he dies and his estate tax is computed, the first step is to deduct all obligations he owes, funeral expenses, estate administration costs, uninsured casualty losses, and state death taxes paid on charitable bequests. Suppose these amount to \$20,000, leaving an adjusted gross estate of \$200,000. As stated, the marital deduction is whatever the deceased leaves his wife *outright* or under an arrangement involving a nonterminable interest, up to *one-half* of his adjusted gross estate. Thus, if he leaves his wife \$50,000, then that amount is the marital deduction. If he leaves her \$100,000 outright, then \$100,000 is the marital deduction. If he leaves her the entire \$200,000 outright, then the marital deduction is still only \$100,000 because of the 50 per cent ceiling. Thus, the marital deduction in this estate can be any amount up to \$100,000.

Here is what the absence of a will in Illinois, for example, can mean in the case of the marital deduction. Under Illinois law, in the case of a husband dying without a will and leaving children, the wife automatically is entitled to an undivided one-third and the children to an undivided two-thirds of the estate.

Therefore, where a husband dies intestate (without a will) and the estate is, say, \$200,000, the wife would get \$66,666 outright from the husband, and the children would receive the balance. This means that the marital deduction would be \$66,666, with a resulting tax liability of about \$13,000. By the simple expedient of a will leaving half the estate to the wife, the estate tax would be \$4,800, a tax reduction of over \$8,000.

The Life Underwriter and Wills. Typical of the genuine importance of the position of the life underwriter is the substantial service he can render to his policyholders by discussing wills.¹⁸ Rarely will an attorney ask a client about his will. To do so is considered unethical. He must wait for the person

¹⁷ The adjusted gross estate is the gross estate minus funeral expenses, administration expenses, debts, state death taxes paid on charitable bequests, and uninsured property and casualty losses suffered during the estate settlement period. (I R C , Sections 2053 and 2054.)

¹⁸ Bar associations are extremely jealous of any action on the part of laymen which they interpret as encroaching on the practice of law. For example, in one instance, a member of the Illegal Practices Committee of a bar association informed a life insurance agency specializing in the sale of insurance for estate planning purposes that he considered it an illegal practice of law for a life underwriter to discuss with a client what provisions should be contained in his will even if the life insurance agent recommended that he consult his lawyer about the changes. The extent to which an agent can enter into a discussion of a will, according to the committee member, is to recommend that the client see his lawyer. Any recommendations as to provisions should be made only to the lawyer who, will then pass them on to the client if the client comes to see him. While this opinion is extreme, it does illustrate the care that agents must exercise in talking to prospects and policyholders about wills.

to come to him—even if he waits so long that the individual dies intestate with all the trouble and loss to dependents an intestacy can produce. But a life insurance agent, who understands what the absence of a will can mean in the case of the marital deduction, for instance, will invariably find out if there is a will.

Living Gifts. One method of reducing estate administration costs and death taxes is to reduce the value of the estate by making living transfers (gifts) of assets to someone else. The motive for the transfer, however, must be strictly a living motive—i.e., the transfer must not be made in contemplation of death, or the gift will be set aside and the property taxed in the decedent's estate.

The Revenue Act provides that transfers of property made more than three years prior to the death of a decedent shall not be taxed as a transfer in contemplation of death. However, if the death occurs during the three-year period from the date of the gift, the presumption is that it was made in contemplation of death. The burden of proof that it was otherwise is on the estate. It is desirable, therefore, to establish clearly that a living motive exists when a transfer of property is consummated. Typical living motives include providing an independent income for relatives, the giver's withdrawal from business, lower income taxes for the donor, and the like.

When a gift is made, a gift tax liability may be incurred. Every individual has a lifetime gift tax exemption of \$30,000. In addition, he has an annual exclusion of \$3,000 *per donee*. If he gives away more than \$3,000 in any one year to any person, his annual exclusion will be exceeded and he must then turn to his \$30,000 lifetime gift tax exemption. For example, if in one year he gives away \$5,000 to each of two persons, the difference between that figure and his \$3,000 annual exclusion per donee must be taken out of his \$30,000 lifetime gift tax exemption, leaving an unused total of \$26,000. If he gives away, say, \$29,000 during the following year to any one individual, he will have entirely used up his \$30,000 lifetime exemption, and from then on he will have left only the \$3,000 annual exclusion per donee. Therefore, in subsequent years if he makes a gift of more than \$3,000 to any one person, the excess over \$3,000 will be a taxable gift.

The foregoing rules apply to single men or women. In the case of married men and women, the rules are more favorable.

A married person may give away, with the consent of the spouse, \$6,000 annually per donee without gift tax liability, and he has a lifetime gift tax exemption of \$60,000 over and above the annual exclusion. This is accomplished by taking advantage of the marital deduction applicable to gift taxes which considers a gift of property owned by either spouse as being made 50 per cent by the wife and 50 per cent by the husband. It is important to note, in connection with gifts made by a spouse, that the law requires the consent of the other spouse before the combined exemptions and exclusions will apply; i.e., if the husband gives away, say, \$6,000, he can claim only a

\$3,000 annual exclusion unless his wife consents to the gift. If she consents, the other \$3,000 is considered as a gift from her. If the gift is one of \$8,000, then \$4,000 is considered as a gift from each spouse so that \$1,000 is deducted from the \$30,000 lifetime exemption available to each party.

Even when gifts are subject to a gift tax liability, they are quite likely to be taxed at a rate far lower than the same amount of property would have been taxed under the estate tax rate. For one thing, the gift tax rate is about 25 per cent less than the estate tax rate. The actual differential, however, is likely to be greater, since both tax structures are progressive. For example, a taxable living gift of, say, \$10,000 might be taxed in 10.5 per cent gift tax brackets,¹⁹ whereas if the property had remained in the estate to be transferred at death, it might be taxed in, say, 30 per cent estate tax brackets.²⁰ By taking assets out of high estate tax brackets and placing them in tax-free or low gift tax brackets via living transfers, more of the estate can be conserved for the beneficiaries.

Estate plans often include gifts of life insurance and annuities on the lives of the donee. It is especially popular to make these gifts to children and grandchildren. In the absence of conclusive evidence to the contrary, gifts of life insurance and annuities generally are considered as originating from a living motive. Insurance is a valuable asset for the donee and is a good gift medium. It is likely to be held by the insured until needed for a given and necessary purpose rather than haphazardly dissipated in careless spending and investing. Also, a life insurance policy can be paid for on an annual basis so that the donor can take advantage of the annual \$3,000 exclusion available for each donee.

Trusts. Another instrument used effectively in estate planning is the trust, testamentary or living. Under a trust, the donor (settlor) transfers property to a second person (trustee) for the benefit of a third party (beneficiary).²¹

Testamentary Trusts. A testamentary trust is a trust created under a will: Bob provides under his will that certain assets go to Irwin in trust for Margaret. The trust, therefore, does not become operative until the death of the settlor.

A number of reasons may impel a man to create a testamentary trust. He may wish to arrange for professional management of the estate; he may want to control the use of the estate income; he may have minor children for whom otherwise a guardian of the property would have to be appointed; he may wish to protect the estate from the creditors of the beneficiaries through a spendthrift trust clause; or he may wish to reduce estate taxes and estate settlement costs. Only the last of these reasons needs elaboration.

A testamentary trust will not reduce estate taxes upon the death of the

¹⁹ This assumes that taxable gifts of \$20,000 have already been made.

²⁰ This assumes a taxable estate of \$150,000.

²¹ The settlor may not be the sole beneficiary under a trust, although he may be a co-beneficiary.

testator nor will it reduce estate settlement costs. The potential trust property remains in the estate of the testator until distributed to the trust after the will is probated. It is handled and taxed like all other property. The trust, however, can be set up to reduce taxes and administration cost upon the death of the trust beneficiary. If the trust beneficiary is given a life interest only in the trust income and does not hold a general power of appointment over the trust property at her death, the property is not taxable in her estate.²² In this way successive death taxes are eliminated.²³ Since the property does not enter her estate, it need not go through probate; so these costs also are not incurred.

Living Trusts. A living trust is one that becomes operative during the lifetime of the creator. Living trusts may be either revocable or irrevocable.

REVOCABLE TRUSTS. A revocable trust is one in which the creator reserves the right to terminate the trust and reacquire the property. Aside from the advantages offered to the creator by the testamentary trust, the revocable living trust offers additional uses. The creator can reduce estate administration cost if the trust remains in force after his death. Furthermore, the beneficiaries will continue to receive their allocated income (and principal) after the death of the creator without having to wait until a will is probated. Finally, a revocable trust, by meeting certain standards, can offer income tax advantages.²⁴ Investment income can be transferred from the higher tax brackets of the creator to the lower tax brackets of the trust or its beneficiaries by placing the investment property in trust.²⁵ Furthermore, if the property is not sold before the death of the creator, the value at the creator's

²² A general power of appointment is one which may be exercised in favor of the trust beneficiary, her estate, or her creditors. The trust beneficiary, however, may be given the right to invade the principal if this power is limited to amounts needed for necessary support, education, or medical care.

²³ The federal estate tax law allows an estate tax credit, however, on prior transfers to decedents as follows.

Within 2 years	100% credit
Within 3 or 4 years	80% credit
Within 5 or 6 years	60% credit
Within 7 or 8 years	40% credit
Within 9 or 10 years	20% credit
Over 10 years	0% credit

²⁴ Income from a trust will not be taxable to the grantor unless the corpus will revert to him within ten years after the trust is created; he can terminate the trust within ten years after its creation; he can control the use of trust property or income; he can use the trust income for his own benefit, or he may exercise administrative powers for his own benefit. I.R.C., Section 673(c), dealing with short-term reversionary trusts, makes an exception to the first rule above if the reversionary interest is not to take effect until the death of the beneficiary. The short-term reversionary trust is discussed later in this chapter.

²⁵ If the trustee has discretionary powers as to how to distribute the income among beneficiaries, the trust is called a "sprinkling" trust.

death becomes the acquisition cost for computing capital gains in the event of a sale thereafter.²⁶ This latter tax advantage gives the revocable trust an edge over *inter vivos* gifts if no estate tax problem is involved.

In a revocable trust, the transfer of property from the grantor to the trustee does not constitute a taxable gift, but payments of income from the trust to the beneficiary do result in a taxable gift by the creator.

IRREVOCABLE TRUST. An irrevocable trust is one in which the creator has not retained the right to terminate the trust and reacquire its property. The principal advantage of the irrevocable trust over the revocable trust in estate planning is the reduction of death taxes. An absolute and irrevocable transfer of property to a trust takes the property out of the grantor's estate and eliminates the estate tax on it. The transfer, however, becomes a taxable gift.²⁷ The same income tax advantages are available under the irrevocable trust as under the revocable trust with one exception: The grantor's cost basis plus any gift taxes paid on the transfer will govern acquisition costs for establishing capital *gains*, even though the sale takes place after the death of the insured. If the fair market value of the property at the time of the transfer is less than the grantor's cost basis plus gift taxes, the basis for determining capital *losses* will be the fair market value at the time of the transfer.

Short-Term, Reversionary Trusts. Short-term, reversionary trusts—i.e., trusts under which the corpus (body) of the trust or the income therefrom reverts to the grantor after a specified period or event—were long the subject of litigation and confusing Internal Revenue Service regulations until the Revenue Act of 1954, which clearly defined their taxable status. The 1954 law opened the way to effecting legal tax savings through such trusts, which savings can be combined advantageously with life insurance in a number of ways, some few of which will be mentioned by way of illustration.

Generally speaking, the 1954 Revenue Act provides that the grantor will not be subject to tax on the income of a noncharitable trust if the term of the trust is for at least ten years or until the death of the income beneficiary, whichever occurs first, if the income is not paid to or accumulated for the benefit of the grantor or used to discharge one of his legal obligations. (The term for a charitable trust is two years if the income is payable to a

²⁶ The standards indicated in footnote No. 24, of course, do not have to be met to enjoy this latter advantage since the trust property is taxable in the grantor's estate.

²⁷ Whether the \$3,000 annual gift tax exclusion allowed for each donee applies to gifts in trust depends upon whether the gift is of a present rather than future interest. The exclusion applies only to present interests. A present interest is an unrestricted right to immediate use of such property or the income from it. For example, if a trust is created under which the income is to be paid to the wife as long as she lives, with the trust property passing to the son upon the wife's death, two gifts are considered to have been made. The wife receives a present interest in the form of a life estate, whereas the son receives a future interest in the form of a remainder interest. The \$3,000 exclusion applies only to the gift to the wife.

specified church, church organization, tax-exempt school, or tax-exempt hospital.)

The short-term trust, therefore, offers persons in higher income tax brackets a chance to transfer income from property or securities from their own, higher tax brackets to the lower tax brackets of the trust or trust beneficiary, or both, without the necessity of giving away the corpus of the trust permanently. Thus, for instance, a parent in 59 per cent tax brackets can save on his tax bill by placing some of his income-producing property in a short-term, reversionary trust. Under this arrangement, instead of 59 per cent of the income from the property going for taxes, as it would if received by him, the income is paid to the trust and is taxed at the lower rate applied to the lower income of the trust or trust beneficiaries.²⁸

Such a trust can be set up with the trustee directed to use the income to purchase various types of life insurance, such as educational insurance on a child, insurance on the wife of the grantor, insurance on a partner or co-stockholder, and insurance on a son during the first few years of his marriage when his need for protection is high but his ability to pay is low. The short-term trust may also be used to provide an income to help support relatives where there is no legal obligation to do so; or to help a son get started in his business or profession.

It is even possible to set up such a trust to pay for life insurance on the life of the grantor if (1) the income is payable directly to a trust beneficiary who has (2) the full authority to use the money in any way he or she sees fit. If there is no trust requirement or other binding agreement that the income is to be used to buy insurance on the grantor, but the trust beneficiary so uses it of his or her own free will, then the insurance so purchased will be considered to be owned by the beneficiary and not includible in the grantor's estate at the time of his death. Thus a temporary trust could be set up for ten years and the income used by the trust beneficiary (voluntarily and entirely at the beneficiary's option) to purchase ten-pay whole life. At the end of the ten years, the insurance will be fully paid up and will be the property of the beneficiary. The corpus of the trust could then revert to the grantor. The insurance would have been paid for out of favorably taxed income (compared to the tax that would have been paid had it been income to the grantor), and yet the corpus of the trust not permanently lost to the grantor.

Short-term reversionary trusts constitute taxable gifts, the amount of which is the value of the transferred property minus the value of the grantor's retained interest. The Internal Revenue Service provides tables for calculating these values. The factor for a ten-year reversionary trust is .291081. Thus, a taxable gift of \$29,108.10 would be involved in the transfer of \$100,000 into a ten-year reversionary trust. Should the grantor die during the effective

²⁸ If the income is accumulated, it is taxable to the trust. If it is paid to the beneficiary, it is taxable to the beneficiary.

period of the trust, only the discounted or reversionary value of the trust will be included in the grantor's estate for estate tax purposes. In the above case this value will range from \$70,891.90 if death occurs in the first year to \$96,618.40 if death occurs in the tenth year. Small savings, therefore, in estate taxes are possible under the short-term reversionary trust.

Life Insurance Trust. A life insurance trust is a type of living trust under which the property involved consists wholly or partly of life insurance policies held by and/or payable to the trust. The policies can be made payable to the trust either by beneficiary designation or by assignment. The procedure to use depends upon the purpose of the trust. If the sole purpose of the trust is to collect, invest, and distribute the proceeds of the policies, this purpose can be accomplished by naming the trustee as beneficiary under the policies. If the trust is irrevocable, the trustee should be named as an irrevocable beneficiary. Where the trustee is to perform certain duties with respect to the policies during the lifetime of the insured or where the policies are to constitute living gifts to the trust, a transfer of the policy to the trustee by assignment is the appropriate procedure. In the latter case, the trustee also should be named the beneficiary.

Life insurance trusts are frequently used in business insurance situations to be discussed in Chapter 18. This chapter is concerned with personal life insurance trusts.

A life insurance trust may be funded or unfunded. Under the *funded* insurance trust, the trustee has the obligation to pay the premiums on the insurance from property transferred to him by the grantor. The premiums are paid either from the trust income or from trust property if the trust income is insufficient. The trust may be partially funded with the grantor paying that part of the premiums which cannot be met out of trust income. In an *unfunded* trust, the premiums are paid directly by the insured. No property is turned over to the trust to fund the premiums.

One of the uses of a life insurance trust has already been discussed: to provide estate liquidity. Other uses are to integrate the insurance estate with the other estate in order to achieve a single plan of estate administration; to gain more flexibility in insurance settlements than are available through life insurance settlement options; to make the appointment of a guardian of the property unnecessary in cases where the insurance proceeds are for the benefit of minors; and to arrange for the investment of life insurance proceeds in types of securities likely to offer some hedge against inflation.

TAX ASPECTS OF LIFE INSURANCE TRUSTS. The tax consequences of a life insurance trust depend upon whether the trust is revocable or irrevocable, the same as in other living trusts. If *revocable*, there are no tax consequences, whether funded or unfunded; i.e., no gift tax liability is incurred, and there are no special income or estate tax savings. In an *irrevocable* funded life insurance trust, there are no income tax consequences if the income from

trust property is earmarked to pay premiums on the life of the grantor. Such payments are considered taxable income to the grantor.²⁹

The values of the policies turned over to an irrevocable trust and the future premiums paid on them by the insured are taxable gifts. Whether the \$3,000 annual gift tax exclusion applies to these gifts depends upon whether the trust beneficiary is given a present or future interest in the policies. To establish a present interest and thus allow the donor the \$3,000 annual exclusion, the trust beneficiary must be given an immediate right to the policy and to all its benefits. If the trust beneficiary is the grantor's wife, he is entitled to a 50 per cent marital deduction only if she has the right to the trust income during her life, and is given a general power of appointment over the trust principal. As for the life insurance, she must have the right either to obtain the policies or to force the trustee to cash them in and invest their surrender values in income-producing assets.

The insurance policies are treated at death in the same way they would have been treated had there been no trust: The proceeds are not part of the insured's taxable estate if he has retained no incidents of ownership in the policy.³⁰ As for property transferred to a funded life insurance trust, the same principles of estate taxation apply as are applied to any other living trust.

Joint Ownership With Right of Survivorship. A useful device for estate transfer is joint ownership. Real estate may be held in joint tenancy, which means that upon the death of a co-owner, the property automatically passes to the surviving owners, and not to the heirs of the deceased.³¹ Two or more people may also own personal property as joint owners. For the property to pass automatically to the surviving co-owners, they must clearly specify that they hold the property as joint owners with right of survivorship and not as owners in common.

The advantage of joint tenancy and joint ownership with the right of survivorship is that the property automatically passes to the survivor without passing through the deceased's estate for administrative purposes. This arrangement has no federal estate tax advantages, however, because if the deceased paid for the property from his own funds, the full value of the property is taxable in his estate. There might be some state death tax advantages because a few states exempt jointly held property entirely, and some others tax only the fractional interest held by the deceased as though the property were held in equal shares as tenants in common. A number of

²⁹ I.R.C., Section 677(a)(3). If, however, the income is used to pay premiums on the lives of persons other than the grantor, the income is taxable to the trust and not to the grantor.

³⁰ If, however, the trustee is under *legal* obligation to use the proceeds on behalf of the insured's estate, they become taxable in the insured's estate.

³¹ When co-owners wish to leave their interests to their heirs rather than to the surviving owner, they must hold the property as tenants in common rather than joint tenants.

states treat jointly held property in the same manner as it is treated by the federal government the share paid for by the decedent is taxable.³²

There may be some federal tax disadvantages to the creation of joint tenancy or joint ownership with right of survivorship. As between husband and wife, the creation of joint ownership in *personal property* will be treated as a taxable gift made by the tenant whose proportional interest in the property is less than his proportional contribution to the purchase price.³³ As between others than husband and wife, the creation of a joint tenancy in real estate as well as in personal property can result in a taxable gift.³⁴ Thus, gifts of joint ownership have the disadvantage of incurring possible gift tax liability without any offsetting decrease in estate tax liability.

In small estates where potential gift and estate tax liability create no problem, a gift in joint ownership with right of survivorship has an advantage over a full ownership gift or a gift as tenants in common. It will accomplish the purpose of reducing estate administration cost while at the same time giving the wife, as surviving owner, a new cost basis for figuring capital gains in event the property is sold after the husband's death. The new cost basis will be the value at the husband's death rather than the original cost to the husband.³⁵ In the event of inflation, this is an advantage since the value at death is likely to be greater than the original cost.

In the larger estate the use of joint ownership with right of survivorship might not be desirable. Factors to consider in making the decision are: the gift tax problem; the problem of successive taxation in the estate of the survivor; the problem of proving the amount contributed by the survivor to the purchase price; and the problem of assuring that the property will be distributed according to the desires of the estate owner. In this latter connection, he will have no assurance that a second husband of his widow may not gain more from his estate than will his children.

Business Interests. When the estate includes a business interest, life insurance can play a major role in estate plans. As will be discussed in Chapter 18, death of the owner can cause severe shrinkage in the value of the business interest. When the owner of a business dies, the business is

³² By way of example, Missouri law provides that property held jointly with right of survivorship passes to the surviving co-owner tax-free, except where the joint ownership was created in contemplation of death; Illinois law provides that jointly held property is taxable as if the property had been held in equal shares in tenancy in common; Wisconsin law provides that jointly held property is taxable to the extent of the decedent's fractional interest in it; Iowa provides that property held jointly with the right of survivorship is taxable to the survivor, except such part as can be shown to have originally belonged to the survivor and never belonged to the decedent, and Indiana law is the same as Iowa law except that real estate held as tenants by the entirety (a joint estate with right of survivorship between husband and wife) is not taxed.

³³ Joint bank accounts and government savings bonds are excluded

³⁴ I.R.C., Section 2515, provides that a joint tenancy in real estate between spouses shall not be treated as a gift even though all or most of the purchase price is contributed by one spouse.

³⁵ I.R.C., Section 1014(b)(9).

either liquidated or reorganized. Estate planning considers these possibilities, and in either situation use is frequently made of life insurance.

If the decision is to liquidate the business, life insurance might be necessary to facilitate this liquidation and to protect the general estate from business debts. Estate planning for business liquidation is usually confined to sole proprietorships. In partnerships and close corporations, the plan is nearly always one of reorganization. Life insurance is used to finance a buy-and-sell agreement.³⁶ Each partner or stockholder will insure the lives of the others so that upon a death, life insurance will be available to the survivors to purchase the interests of the deceased at the agreed-upon price. The plan assures that the business interest will be liquidated promptly and fairly and will thereby reduce the cost of estate administration.

6. EXAMPLES OF ESTATE TAX PLANNING.

The difference that estate planning can make in the conservation of an estate may be illustrated by the following examples. These examples are confined to estate tax planning only, but similar illustrations could be developed to demonstrate the advantages of planning for other estate shrinkage factors.

Assumptions. The following plans assume that the husband predeceases his wife by at least ten years and that the wife's share received after the husband's death is fully intact at her death. Also, it is assumed that the husband has not previously utilized his lifetime gift tax exemption. An adjusted gross estate of \$200,000 is assumed for a married man with two children.

The Plans. Six estate plans are outlined.

Plan 1

Leave \$200,000 life estate³⁷ to wife by will giving her no power of appointment of the remainder at her death

Tax when husband dies	\$31,500 ³⁸
Tax when widow dies	None
Net retained by wife	\$168,500
Net acquired by children	168,500

There is no second tax when the wife dies because the property was neither given to the wife outright nor did she have a general power of appointment of the remainder at her death. For these same reasons, the estate did not qualify for the marital deduction.

³⁶ See Chapter 18.

³⁷ A life estate is an arrangement whereby the beneficiary has the right to enjoy the income as long as he or she lives. Upon death of the beneficiary, the property goes to a secondary beneficiary who has already been named by the husband.

³⁸ Tax rates used throughout this chapter are those in effect at the time of this writing.

Plan 2

Leave \$200,000 outright by will to wife		
Tax when husband dies	\$ 4,800	
Tax when widow dies	30,136	
Net retained by wife		\$195,200
Net acquired by children		165,064

The reason for higher taxes upon the death of the widow is that her estate will not have the benefit of the marital deduction.

Plan 3

Leave \$100,000 outright to wife by will		
Leave \$100,000 life estate to wife by will without power of appointment		
Tax when husband dies	\$4,800	
Tax when widow dies	4,044	
Net retained by wife		\$195,200
Net acquired by children		191,156

In this plan the husband leaves his wife half the estate *outright* and the other half in a life estate. When the husband dies, the half he leaves his wife outright (\$100,000) qualifies for the marital deduction. To the marital deduction is added the \$60,000 estate tax exemption, leaving a final net taxable estate of \$40,000 on which the estate tax is \$4,800. When the widow dies, only the amount left to her outright is taxable. Since she retained \$95,200 after taxes, her taxable estate, after the \$60,000 exemption, will be \$35,200 which will yield a tax of \$4,044.³⁹

Plan 4

Leave \$100,000 life estate to wife by will without power of appointment		
Liquidate one-half of his holdings (\$100,000), which will buy \$150,000 single-premium life insurance on husband (payable to wife)		
Tax when husband dies	\$10,900	
Tax when widow dies	15,128	
Net retained by wife		\$239,100
Net acquired by children		223,972

In this plan it is assumed that the husband is using one-half of his holdings (\$100,000) to buy single-premium life insurance on his life, and that he retains incidents of ownership in the policy. The life insurance proceeds qualify for the marital deduction up to \$125,000 (one-half of the estate) leaving a taxable estate of \$65,000 after the \$60,000 exemption.

If the insured gives up all incidents of ownership in the policy, his estate tax liability will be reduced to \$4,800 since his taxable estate would be only

³⁹ For simplicity these illustrations ignore the deductions for funeral expenses, administration costs, debts, etc. in the widow's estate

\$40,000.⁴⁰ However, he would incur a gift tax liability of \$953,⁴¹ so his net tax savings would be \$5,147.⁴² The tax liability in the widow's estate will be increased, but only to the extent of the tax on the additional estate made possible by the tax savings in the husband's estate. The widow's taxable estate will be \$84,419,⁴³ which will yield a tax of \$16,337. The net acquired by the children would be \$228,082, an increase of \$4,110 as a result of the insured's giving up the incidents of ownership in his life insurance.

Plan 5

Leave \$100,000 life estate to wife by will without power of appointment

Leave \$50,000 outright to wife by will

Buy and give now a \$25,000 single-premium annuity to son on his life

Buy and give now a \$25,000 single-premium annuity to daughter on her life

Tax when husband dies	\$4,800	
Tax when widow dies	None	
Net retained by wife		\$145,200
Net acquired by children		195,200

In this plan the \$50,000 left outright to the wife qualifies for the marital deduction, since it is less than one-half of the adjusted gross estate, which is now \$150,000. The \$50,000 in annuity gifts to the children will not incur a gift tax liability if the wife consents because of the privilege of splitting gifts. The husband and wife have a joint \$6,000 annual exclusion per donee, and a joint lifetime exemption of \$60,000.

Plan 6

Leave \$75,000 life estate to wife by will without power of appointment

Leave \$75,000 outright to wife by will

Buy and give now a \$25,000 single-premium annuity to son

Buy and give now a \$25,000 single-premium annuity to daughter

Tax when husband dies	\$1,050	
Tax when widow dies	935	
Net retained by wife		\$148,950
Net acquired by children		198,015

This plan takes full advantage of the marital deduction leaving the widow one-half of the adjusted gross estate. The husband's taxable estate

⁴⁰ \$100,000 — \$60,000.

⁴¹ The value of the gift would be \$100,000, the cost of the policy. A marital deduction of \$50,000, a lifetime exemption of \$30,000, and an annual exclusion of \$3,000 reduces the taxable gift to \$17,000 which, according to the gift tax rates, yields a tax of \$953.

⁴² \$10,900 — (\$4,800 + \$953). Actually, the tax savings will be a little more, since payment of the \$953 in gift taxes reduces the estate by that amount, thus reducing estate taxes another \$172.

⁴³ 150,000 — (953 + 4,628 + 60,000).

will be only \$15,000.⁴⁴ The widow's taxable estate will be only \$13,950,⁴⁵ since the life estate does not incur a second tax.

The Wife Dies First In the above illustrations, it was assumed that the husband dies first. But what happens if the wife dies before the husband? What is the amount of the estate tax due when the husband subsequently dies? Take plan 3, for example. If the wife is not alive when the husband dies, there can be no marital deduction. In that case the tax is \$31,500 instead of \$4,800.

Since there is usually no way of predicting accurately who will die first, life insurance on the wife could be used to offset the loss of the marital deduction. The husband can insure his wife (naming the children as absolute and irrevocable beneficiaries) for the amount of the excess tax liability payable (\$22,656),⁴⁶ or the children can insure their mother's life for that amount. Then the children will have \$22,656 of life insurance proceeds if the mother dies first. Subsequently, at the death of the father, the net estate received by the children will amount to \$168,500 after taxes. Accordingly, the children's inheritance will finally total \$191,156, of which \$22,656 came to them at their mother's death and \$168,500 at their father's death.

Which Plan Is Best? The answer to this is a personal one. Decide first on objectives, and then develop the plan which best meets these objectives.

These examples of estate tax planning are given as indications of the many combinations that can be made in estate planning with and without the utilization of life insurance to accomplish desired, specific objectives.

Life underwriters frequently hear: "I am much more interested in the welfare of my children than I am in the future of my wife. She may get married again; she is extravagant; and the plan I want is one where my wife will have enough income during her lifetime but in which she cannot touch the principal."

Such an arrangement can be made and in a way which will still save estate taxes. Two life estates or trusts may be arranged. In one of them the wife will get the income for her lifetime, and at her death the remainder will go to the children. In the second life estate or trust, the wife will get all the income during her lifetime and will have the power to leave the property to any one she chooses at her death.

These two different types of life estates contain different powers of appointment. In one, the wife is limited to leaving the corpus of the estate to persons designated by the husband. In the other, she may leave it to anyone.

When the wife has the power to leave the corpus to anyone she chooses, it will qualify for the marital deduction at her husband's death but will be fully taxable in her estate at her death. When she is restricted in appointing the persons to receive the corpus at her death (the children, in this case), the

⁴⁴ \$150,000 — (\$75,000 + \$60,000).

⁴⁵ \$75,000 — (\$60,000 + \$1,050).

⁴⁶ \$31,500 — (\$4,800 + \$4,044).

corpus will be taxed in her husband's estate, but it will not be subject to tax again in her estate when she dies.

7. INCOME TAXATION OF LIFE INSURANCE POLICIES.

It is impossible in a text such as this to discuss all the income tax aspects of life insurance policies. Only the common, everyday questions are treated here.⁴⁷

Taxation of Proceeds. Proceeds of a life insurance policy may be payable in a lump sum, in fixed installments, or as a life income to the beneficiary. They may also be held at interest. Proceeds paid as a lump sum by reason of death are not taxable as income. The one exception to this rule involves policies transferred for value. If A purchases from B an existing policy for \$10,000 on B's life, paying B \$3,000 for it, and then pays another \$1,000 in premiums before B's death, he is taxed on the \$6,000 gain. The rule is that if a policy is transferred for value, income tax is payable on the difference between the proceeds and the purchase price plus premiums paid by the transferee. Two exceptions to this rule are: (1) If the transferee is the person whose life is insured, no income tax liability is incurred on the gain, and (2) no income tax liability is incurred where the policy is transferred to a partner of the insured, to a partnership in which the insured is a partner, or to a corporation in which the insured is a shareholder or officer. Note, however, that a transfer between stockholders does not fall within this exception.

Proceeds payable under a fixed installment option involve taxable income. Only that portion of each installment settlement representing a return of principal is excluded. The law seeks to tax only the interest, and even here a surviving spouse is allowed an annual exclusion of \$1,000 in otherwise reportable income. For example, if the widow receives ten annual installments of \$11,380 instead of a lump sum of \$100,000 she will report only \$380 annually as taxable income. Ten thousand dollars is excluded as return of principal and \$1,000 is tax-free under the widow's exclusion, leaving only \$380 as taxable income. If the beneficiary were someone other than a surviving spouse, taxable income would amount to \$1,380 annually.

Proceeds payable as a life income also involve reportable income. In this case the net policy proceeds are divided by the life expectancy of the beneficiary at the insured's death, using the same mortality table used by the insurance company in computing the benefits. The amount obtained is the annual deduction. The excess is reportable as income subject to the \$1,000 annual surviving spouse exclusion. If the life income option guarantees a minimum number of payments, as is customary, then before prorating the proceeds over the life expectancy, the actuarial value of the guaranteed pay-

⁴⁷ For up-to-date information on federal income, estate, and gift taxes as they relate to life insurance, see the *R & R Tax Handbook*, published by the Research and Review Service, 123 West North Street, Indianapolis, Indiana.

ments is subtracted from the proceeds. The actuarial value of the guaranteed payments is found by computing the present value of the contingent beneficiaries' interest using the mortality and interest assumptions applied by the company in figuring the option. Period certain benefits paid to a contingent beneficiary are taxed only to the extent of any excess interest paid.

If the proceeds are left at interest, the entire amount of the interest payable is subject to the income tax in the year paid. There is no \$1,000 exclusion for the surviving spouse.

Any "excess interest" paid under any of the above options is treated the same as guaranteed interest, and will be taxable subject, of course, to the \$1,000 surviving spouse exclusion where applicable.

In general, the \$1,000 surviving spouse exclusion applies only if the settlement option selected is a contractual right, either contained in the policy or made a part of it by endorsement prior to the insured's death. Only one surviving spouse exclusion can be taken regardless of the number of policies the deceased held. However, a widow may have two exclusions if she has survived two husbands and if both husbands left her insurance.

Taxation of Endowment Policies. The difference between the net proceeds paid by the insurance company and the total premiums paid by the policyholder for the insurance represents taxable income to the insured when an endowment policy matures as a living claim.

For instance, assume a person buys a \$10,000, twenty-year endowment and his total premiums less dividends and charges for double indemnity, waiver of premium, and disability income over the twenty years amount to \$9,000. The policy matures, and he receives a \$10,000 check from the insurance company. The \$1,000 gain is subject to the income tax as ordinary income, not as a capital gain. However, the tax cannot exceed the amount the tax would have been had the gain been taxed ratably over the taxable year in which the proceeds are received and the two preceding taxable years.

If the policyholder is in high income tax brackets and a large amount of life insurance is involved, he may prefer to spread the gain over a period longer than three years by taking proceeds in installments. In this case income taxes will be payable on that part of each annual installment which represents interest. The amount subject to tax is computed in the same manner as the tax on annuity income is figured.⁴⁸ The basis for the cost of the contract is the sum of the net premiums paid.

If the policy does not include an installment option, or if the option is exercised after the expiry of sixty days beyond the maturity date of the policy, the full gain will be taxed as ordinary income under the doctrine of constructive receipt. If the policy proceeds are then paid in installments, the cost basis of the contract for income tax purposes becomes the face of the contract rather than premiums paid.

⁴⁸ Cf. Chapter 5.

Taxation of Cash Values. Two questions are important in discussing the taxation of cash values of life insurance policies: (1) the growing cash values of policies while they are in force and (2) the cash values of policies upon surrender.

Annual increments in cash values are not subject to income taxes. There can be no income tax on cash value accumulations until the policy is surrendered, and then the excess of surrender value over net premiums paid is taxable as ordinary income. The tax on this gain, however, cannot exceed the aggregate of the taxes attributable to such gain had it been received pro rata over the past three years. Thus, if an insured surrenders a policy for \$25,000 on which he has paid \$16,000 net in premiums, he will be taxed on \$9,000. The amount of the tax can not exceed the aggregate of the tax on \$3,000 in the year received and that produced by a tax on \$3,000 added to the income already reported in the two preceding years. It can, however, yield a lower tax. For example, if the year in which the policy is surrendered is one in which the tax brackets are much lower than those of the past two years, taxation of the full amount in that year might result in a lower tax liability than would be the case under the three-year distribution plan.

It is not necessary to subtract the cost of insurance from the premiums paid in computing the gain. Therefore, all the gain is not taxable. That part which was used to pay premiums, in effect, is excluded. In the above illustration, if the actual cost of insurance protection received over the life of the policy was \$8,000, then the insured actually gained \$17,000⁴⁹ rather than \$9,000, although only \$9,000 is taxable.

If the cash values are taken under an installment or annuity option, and a tax liability is involved, the rules governing the tax are the same as those applicable to endowment proceeds settled under income options.

Taxation of Dividends. Dividends on life insurance policies are not taxable income because they constitute a premium refund. If dividends are left with the company to accumulate at interest, the amount of interest credited is taxable in the year credited. If the policyholder does not have the privilege of withdrawing the interest without withdrawing his accumulations in full, the interest is not currently taxable.⁵⁰

Dividends applied to buy paid-up additions or one-year term insurance create no tax liability. They are viewed as dividends received in cash and then used to buy single-premium insurance.

Taxation of Conventional Annuities. Receipts under an annuity policy are taxed each year according to the formula described in Chapter 5. Briefly, the amount subject to the income tax is the annual annuity income less the amount which, according to the Internal Revenue Service, represents a pro-

⁴⁹ \$25,000 — (16,000 — 8,000) = \$17,000. The actual amount invested was only \$8,000, since the other \$8,000 was used to purchase the protection which the insured enjoyed over the life of the policy.

⁵⁰ *Massachusetts Mutual Life Insurance Company v. U.S.*, 288 U.S. 269.

portionate return of principal or what the Service calls the expected return. The return of principal (called "annual exclusion") in an annuity certain is found by dividing the purchase price by the number of years over which installments are paid. The amount excluded each year under a life annuity is found by dividing the purchase price by the expected total return and then multiplying the guaranteed annual return by the resulting fraction. The figure obtained is excluded and the remainder is taxable as ordinary income. The total expected return is found by multiplying the guaranteed annual income by the life expectancy of the annuitant determined from tables furnished by the Internal Revenue Service. An illustration of the application of the formula is developed in Chapter 5.⁵¹ If payments are for a period certain and life thereafter, the cost is reduced by the actuarial value of the guaranteed payments for the period certain. The values of payments certain and of refund features are calculated by use of special tables provided by the Internal Revenue Service. The annual exclusion continues throughout the life of the contract even though the annuitant has already received a full return of his principal tax-free. The amount of the exclusions at that time represent insurance gains rather than a return of principal and as such are not taxable.

Taxation of Variable Annuities. Payments received under a variable annuity contract are taxed in much the same manner as payments under the fixed-dollar annuity. The annuitant divides the amount of his net investment in the contract by his tabular life expectancy and deducts the resulting figure each year from his annuity income as a return of principal. The remainder is taxable income. As in the fixed-dollar annuity, he deducts the actuarial value of any refund feature in figuring the amount of his net investment. If the total payments received in any one year are less than the annual excludible amount, the annuitant may elect to take a new start for the next year. In this event, he recalculates both his net investment in the contract and his life expectancy as of the new starting date.⁵²

Taxation of Health Insurance. In general, benefits paid under individually owned health insurance policies are not includible as gross income for the federal income tax.⁵³ Premiums paid on policies providing reimbursement for medical care expenses (including amounts paid for the diagnosis, cure, mitigation, treatment, or prevention of disease or for the purpose of affecting any structure or function of the body, and for transportation essential to medical care) are includible in calculating the medical expense deduction on personal income tax.⁵⁴

⁵¹ See page 99 f.

⁵² Reg. 1.72-2(b)(3), 1.72-4(d)(3), 1.72-5(f), and 1.72-7(d).

⁵³ I.R.C., Sections 101 and 104(a)(3); Reg. § 1.101-1(a). However, benefits received in one year from a policy or policies covering medical-hospital and similar reimbursement costs must be reported up to the amount of any deduction as medical expense that has been taken for them in a previous year. (Reg. § 1.104-1[d] and 1.213-1(g).)

⁵⁴ Reg. § 1.213-1(e)(1); Rev. Ruls. 19, CB 1953-1, 59; 55-261 CB 1955-1, 307;

In a type of policy known as "business overhead expense," which names certain items of overhead expense for which the insured (a professional man, partner, or sole proprietor) will be reimbursed in case of disability, premiums are fully deductible as a business expense.⁵⁵ However, the proceeds from the policy will be includible as gross income for income tax purposes.⁵⁶ Note, however, that premiums paid on a regular disability income policy are not deductible even though the intent is to use proceeds to pay business overhead.⁵⁷

Death benefits from a health insurance policy paid to the insured's estate or other beneficiary are treated as life insurance policy benefits.⁵⁸

Premiums on Life Insurance. Premiums paid for personal life insurance are not a deductible expense. Interest paid on loans made to finance the purchase of life insurance is deductible except when single-premium policies or annuities are purchased. Interest on a loan to purchase single-premium policies is not deductible; and the law treats as a single-premium any policy which is paid up in less than five years or on which a substantial number of premiums is either prepaid or deposited under a premium-deposit plan.⁵⁹

8. LIFE INSURANCE AND COMMUNITY PROPERTY.

Eight states⁶⁰ have community property systems. In four more states⁶¹ a community property system once operated but has since been repealed.⁶² The reason for the repeal was the Federal Revenue Act of 1948 which made these community property laws no longer necessary. The laws in these states were enacted to achieve for their citizens the federal tax advantages accruing to residents of community property states. The split-income (joint return) provision of the federal income tax law, the split-gift feature of the gift tax law, and the marital deduction granted under both the federal estate and gift tax

and 55-331, CB 1955-1, 271. The Third Circuit Court of Appeals (*Heard v. Commissioner*, 269F [2nd] 911) held premiums for policies providing loss of time benefits as well as medical-reimbursement provisions are fully includible in the medical expense deduction. The Commissioner has refused to follow the decision (Rev. Rul. 59-393, IRB 1959-50, 52), contending that only the pro rata portion of the premium going for the medical-care benefits is includible. (You can do the insuring public a favor by deducting your loss-of-time premiums and then carrying the Commissioner to the court of highest appeal.)

⁵⁵ Rev. Rul. 55-264, CB 1955-1, 11.

⁵⁶ Rev. Rul. 55-264, *supra*.

⁵⁷ *Marvin J. Blaess*, 28 TC 710; Rev. Rul. 58-480, CB 1958-2, 62.

⁵⁸ *Leopold Ackerman*, 15 BTA, 635.

⁵⁹ Restrictions on deductions with respect to annuities apply only to those purchased since March 1, 1954.

⁶⁰ Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, and Washington. These states are the original community property states.

⁶¹ Michigan, Nebraska, Oklahoma, and Oregon. These states were called "new" community property states.

⁶² Since the repealing statutes in these states were not retroactive, the original statutes in these states apply to property acquired during the period that the statutes were in force.

laws equalized the tax treatment between common law states and community property states.

Definition of Community Property. Community property is property owned by husband and wife in common, each having an undivided half interest. What constitutes community property varies slightly among the community property states. Generally, property owned by the husband or wife before marriage and all property acquired after marriage by gift or inheritance, or by purchase from separate funds (and in five states the income from such property), are considered the separate property of each. All other property, except that which the spouses by specific agreement declare to be separate property,⁶³ is community property.

While the wife has an ownership interest in community property, the husband usually is given complete control over its management. In some states ⁶⁴ he may even dispose of the property without the consent of his wife if such disposition is not fraudulent or does not injure the interest of his wife. The husband, however, cannot make gifts of community property without his wife's consent except in four states,⁶⁵ where gifts of moderate size can be made. Either spouse, however, is permitted to dispose of his or her interest in community property by will.⁶⁶

Life Insurance as Community Property. Various problems can arise with respect to life insurance in community property states. To eliminate these problems before they occur, careful planning is necessary. Several general rules can be laid down, but because exceptions and modifications exist among the various jurisdictions, individual legal guidance will be necessary in any given estate planning situation.

General Rules. A life insurance policy purchased before marriage on which subsequent premiums are paid from community funds after marriage remains the separate property of the insured.⁶⁷ The community, however, is given a deferred claim for reimbursement which matures at the dissolution of the community,⁶⁸ or terminates upon the death of the insured if the spouse is the policy beneficiary. Policies taken out after marriage and paid for with community funds are community property. If the estate is named as beneficiary, the death proceeds become a part of the community estate, but if the wife is named as beneficiary,⁶⁹ the proceeds accrue to her as separate prop-

⁶³ Or held in some other manner, for example, like joint tenancy.

⁶⁴ Nevada (except a homestead), New Mexico (personal property only), Texas and Washington (personal property only).

⁶⁵ Arizona, Louisiana, Nevada, and Texas.

⁶⁶ Where the deceased spouse leaves no will, the intestacy laws of the state govern the disposition of community property.

⁶⁷ Exceptions to this rule are found in Washington and California, where the source of the premium money determines policy ownership as between separate and community property under the apportionment rule.

⁶⁸ Death or divorce

⁶⁹ She must be named irrevocable in Texas.

erty. If a third party other than the wife is named as beneficiary, written consent of the wife as well as a waiver of her interest for a consideration are advisable to avoid possible expensive litigation.⁷⁰ Even better, premiums for these policies should be paid from funds which are not community property.

If the insurance is to perform the service intended in his estate plans, the policy-holder must be careful to seek adequate legal counsel, especially on the complicated legal and tax problems that might arise in the community property states.

9. REPLANNING A CONTINUING NECESSITY.

Tax and estate planning for any given estate is not a one-time matter. Re-examination must be a frequent occurrence. In the first place, the situation of the estate owner changes continually. Dependent children grow up. An heir dies. A new heir is born. The nature and character of estate assets change.

In the second place, tax laws, regulations, and rulings habitually change. For instance, at one time life insurance up to \$40,000 was exempt from the federal estate tax. That law was changed, requiring replanning of every estate which had taken it into account. Also, the test of whether a policy was to be included in the estate of the insured once depended on who had the incidents of ownership; the law was changed to add to the test of ownership the question of who paid the premiums; now it has been changed back to the ownership test only; tomorrow it may be changed to some other basis. Before 1948 there was no such thing as a "marital deduction."⁷¹ Once the interest element in limited installment payment of proceeds was nontaxable if the insured elected the option for the beneficiary prior to death; then for a few years it was nontaxable no matter who elected the option; currently it is taxable in any case except for the \$1,000 exclusion to a surviving spouse. Before 1954 jointly owned property took a cost basis equal to the cost paid by the donor-decedent in computing taxable gains on subsequent sale. Now jointly owned property included in the decedent's taxable estate takes a new cost basis—the value at the time of the decedent's death. Also, before 1954, the creation of a joint tenancy in real estate between husband and wife involved a taxable gift. Since 1954 the creation of a joint tenancy between husband and wife in real estate no longer is considered a taxable gift.

Unless frequent re-examinations of any estate plans are made, unnecessary taxes are almost inevitable, to say nothing of delays in estate settlement, losses on estate values, and increased administration costs.

⁷⁰ The beneficiary named in the policy might not otherwise be allowed to claim the full proceeds against the insured's widow. This, of course, is not the law in every jurisdiction. In some jurisdictions, it will be recalled, the husband can make nominal gifts of community property if he does not injure his wife's interest.

⁷¹ Except as such a deduction was obtained in effect in states operating under the law of community property, which is of Spanish heritage, as contrasted to common law, which is of English heritage.

10. SUMMARY.

Life insurance plays a major role in estate planning and the life insurance agent is an essential member of the estate planning team. As an estate asset, life insurance has many important attributes. Cash values increase free of income tax. Policies have their greatest value at death when these values are needed to pay estate taxes and other transfer costs. Life insurance payable to a named beneficiary does not have to pass through probate court; it is free from the claims of the creditors of the insured; and it enjoys death tax advantages in certain states. Life insurance can be so arranged as to qualify for the marital deduction. The use of settlement options eliminates the need for costly trust arrangements. Life insurance is valuable for funding business interest buy-and-sell agreements. It is well qualified as a gift medium.

Other instruments of estate planning are wills, living gifts, trusts, and joint ownership with the right of survivorship. These instruments and their uses (and their limitations, also) must be considered in establishing an estate plan.

In community property states, special problems might arise with respect to life insurance which need the careful attention of counsel.

Perhaps one of the most important advantages of life insurance in the estate plans of anyone is that it makes it possible for a man to provide a comfortable living for his family in case of his death without accumulating a huge estate. With adequate life insurance, a man is free to concentrate more on enjoying what life has to offer rather than being so concerned with the acquisition of property that he loses sight of the importance of living itself.

QUESTIONS FOR CLASS DISCUSSION

1. Why should a professional life insurance agent keep abreast of tax laws?
2. What does it cost to die? Where can accurate data be found on this subject?
3. Why might life insurance be a good investment for a man with a high income? Can disability income insurance be used in estate planning?
4. Explain the federal income, estate, and gift tax applications, if any, of the following life insurance transactions:
 - (a) "A" purchases a \$300 monthly immediate life annuity for the single premium of \$47,000. He dies after receiving an annuity income for ten years.
 - (b) "A" purchased a whole life policy of \$20,000 for a single premium of \$10,574. He surrendered the policy at the end of five years for \$10,052.
 - (c) Assume that in the above case, "A" surrendered the policy at the end of ten years for \$11,020.
 - (d) "A" dies, leaving the proceeds of a \$25,000 policy payable to "B" under a life income option.
 - (e) Excess interest is paid on the guaranteed installments under the above policy.
 - (f) "A" dies and leaves the proceeds of his life insurance policy to his widow under the interest-only option subject to full withdrawal. Six years later,

the widow asks the company to pay her the proceeds on a life-income option. The company agrees.

- (g) "A" gives his wife an allowance of \$200 a month. She uses part of this money to purchase a \$30,000 life insurance policy on A's life. After several years, "A" dies. She has full ownership of the policy
 - (h) "A" left the dividends on his \$20,000 life insurance policy to accumulate at interest. After four years, he drew out the entire dividend accumulation which amounted to \$250.
5. Among the following statements, some are true, others are false. Ignore the true statements and explain briefly why you consider the others false.
- (a) There can be no reportable loss for income tax purposes when a business surrenders a life insurance policy
 - (b) If a limited payment policy is paid up, and year by year the dividends are taken in cash, no income tax is levied upon the dividends as they are withdrawn.
 - (c) Disability income benefits paid to the insured under a health policy are not subject to income taxes.
 - (d) Premiums on health insurance are deductible as an expense for purposes of computing personal income taxes.
 - (e) If the surrender value of a life insurance or endowment policy is settled under a fixed amount or fixed-period option pursuant to a right contained in the contract to do so, there will be no taxable income until the installments received exceed aggregate premiums paid, after which the full amount received is taxable.
 - (f) The same rule as above would apply if the surrender value of a life insurance or endowment policy is settled under a life-annuity option
6. Aside from its principal function—that of providing for estate liquidity—life insurance can be used in a number of other ways as an instrument of estate planning. Describe briefly at least two ways in which life insurance can be used advantageously in estate planning other than that of providing for estate liquidity.
7. Under what types of settlement do life insurance proceeds qualify for the marital deduction for federal estate tax purposes? Why might a person not wish to qualify for the marital deduction?
8. "A" dies and wills his property to his wife, one-half outright and the other half in a life estate. How does this procedure save estate taxes upon the death of his wife? How might the same purpose be accomplished by means of life insurance instead of making a transfer of a life estate by means of a will?
9. Explain how the selection of dividend options, settlement options, and non-forfeiture options might be affected by the tax laws.
10. Evaluate each of the following instruments of estate planning: (a) *inter vivos* gifts, (b) *inter vivos* trusts, (3) named beneficiaries in life insurance, (d) testamentary life estate for the wife, and (e) joint ownership with right of survivorship.

CHAPTER 18

Business Uses of Life and Health Insurance

Life and health insurance are used in a number of ways to protect a business. Since the field of business life and health insurance is highly technical, the insurance agent operating in it usually must work with lawyers and accountants. The lawyer helps with the legal complexities, such as the buy-and-sell agreements, stock repurchase agreements, and special tax issues. The accountant helps with the problems of valuation, premium budgets, and types of purchase plans. The insurance agent's principal contribution is to uncover the needs for life and health insurance in the business and to motivate the owners to satisfy these needs. In addition to the lawyer, accountant, and insurance agent, a fourth party may be involved, a trust officer. A trust company frequently participates in business insurance cases as a stakeholder; when this is true, the trust officer will want to have the agreements checked by his own counsel.

The use of business insurance as a tool in estate planning was mentioned in Chapter 17. Its importance in this area should be better appreciated after studying this chapter.

Four basic uses of business insurance are:

(1) To protect the business against financial loss in the event of the death or extended disability of a key man, and to help attract and retain the key man in the business.

(2) To salvage the value of a sole proprietorship upon the death or extended disability of the owner.

(3) In a partnership, to prevent the liquidation of the business in the event of the death of a partner, and to preserve the value of his share. In the event of the disability of a partner, to prevent heavy financial drains on the partnership, and to preserve the value of his interest.

(4) In a close corporation, to enable surviving shareholders to retain management control and to assure an equitable price for the shares in the estate of the deceased stockholder. In event of disability, to prevent the same type of losses mentioned in the case of partnership insurance.

In addition to these basic uses, business life and health insurance offers collateral advantages in the form of business stability and improved credit.

Business life insurance, under certain circumstances, also offers a source of capital, confidential borrowing, and tax-free additions to surplus.

1. KEY MAN INSURANCE.

Plants, equipment, and material do not make a business unless they are turned into a product which is merchandised by men of technical and executive ability. Wipe out the personnel, and the business is destroyed. An important function of key man insurance is to protect a business against financial loss resulting from the death or disability of a key employee. "What corporate purpose could be considered more essential than key-man insurance?" asked the Federal Court of Appeals for the Third Circuit in a case involving key man insurance.¹ "The business that insures its buildings and machinery and automobiles from every possible hazard can hardly be expected to exercise less care in protecting itself against the loss of two of its most vital assets—managerial skill and experience."

Who Are "Key Men"? The key men in any business are those employees whose loss by reason of disability or death would cause the business a serious financial loss. They are also those employees who are important enough to the business to merit a continuation of their salaries during periods of disability, to an amount beyond that provided under the usual group disability plan or sick leave arrangements established as the personnel policy of the company, and for whom special deferred compensation arrangements may be important to wed them to their jobs. Such people are not always those with titles. They are those whose roles and interest in the business are more than mere drawing of salary. Conversely, the man with a title is not always a key man. He may be a functionary, replaceable with comparative ease. Discovering who are key men in a business requires a careful study of the nature and operation of the particular business at hand.

Examples of key men fall into many categories. Top executives are obvious examples. Less obvious but often equally important are research workers, sales managers and top salesmen, department heads, the company treasurer or accountant—any employee who will be costly to replace because (1) training a new man will take time and money, and/or (2) efficiency in his department will sag sharply while a replacement is being trained.

Protection Against Death or Disability of Key Man. The business protects itself by buying life and health insurance on the key man and naming itself as beneficiary. After determining who the key man is, the problem is to determine how much and what kind of insurance to buy.

Determining Insurable Value. Determining the insurable value of a key man is rarely subject to precise formulas. Usually, the value is arrived at in a largely arbitrary fashion—by guesswork. However, the value arrived at can be an "educated guess" if careful consideration is given to several factors:

¹ *Emeloid Co. v. Commissioner*, 189F. (2nd) 230, p. 233.

(1) *What would it cost to replace the key man if he were to die or become disabled?* It is infrequent, except in a small business such as the typical sole-proprietorship, that any employee, however valuable, eventually cannot be adequately replaced; but such replacement will almost always involve costs. If replacement comes from the "ranks below," it is rarely that the new man can step into the job with no loss of efficiency or production in the department. The probable cost of the reduced efficiency, in terms of profit, needs to be estimated. If the replacement must come from outside the company, a replacement of equal ability will often require a higher salary. In all probability, the desired man is secure in his present position. A new job is a gamble. If nothing else, there may be conflicts of personality even though his work is eminently satisfactory. Therefore, to be attracted, he must be offered a large enough differential to compensate him for the risks of moving. A study of the personnel market might help in estimating the value of a key man in this connection.

(2) *What portion of company profit is traceable to the key man?* In most cases this will probably be difficult to answer precisely; in others, such as that of a salesman, it may be relatively easy to estimate.

(3) *How much investment would be lost if the key man died?* Large sums might be invested in a research or developmental project which would be a total loss in event of the death of a key man. One man might be solely responsible for the development and operation of a specialized department, or he might be the guiding genius or even the sole worker on an expensive advertising or merchandising campaign which would have to be scrapped entirely if he were lost.

(4) *How much of the loss is the company willing to insure?* Since the amount of probable loss in almost all cases is impossible to measure with any degree of accuracy, the amount of key man insurance will depend, not so much on a rough estimate of the key man's value as on the amount of money the company is willing to spend for indemnity in case of death or disability.

In the case of disability there will be, in addition to the loss of the services of the key man, the cost of continuing the employee's salary for a period of time.

Type of Policy. The type of life insurance policy to buy for key man indemnification depends upon whether the policy is to be used for a collateral purpose and the length of time the protection is desired. For example, if the policy is to be used to provide retirement benefits to the employee if he remains with the company, an endowment at age 65 or retirement income policy might be best. If protection is needed for only a few years, then a term policy will qualify. In general, continuous-premium whole life is used if protection against the death of the key man is the sole reason for buying and if the duration of the protection is indefinite.

For key man disability insurance, a separate health insurance policy can be used to handle temporary disability. For permanent and total disa-

bility, a disability income rider can be attached to the key man life insurance policy if it is a permanent form.

The Tax Aspects. The customary arrangement in key man insurance is for the business to purchase the policy, retain all incidents of ownership, pay the premium, and name itself as beneficiary. The key man himself has only to give his permission for the insurance. Aside from that, he is completely outside the transaction.

When the business is the beneficiary, it cannot deduct the premium for life insurance.² The same rule applies with respect to health insurance with one exception. Where professional or business overhead expense health insurance provides *specifically* for reimbursement for the business overhead expenses of a sole proprietor, professional man, or partner in the event of his absence due to injury or sickness, the premiums are deductible.³ Such a policy is considered for tax purposes as in the nature of business-interruption insurance.

The proceeds of a key man life insurance policy paid to the business are specifically exempt from income tax.⁴ By analogy, it would appear that the proceeds paid under key man health insurance would also be exempt. While logic does not always produce the right answer in tax situations, there is reason to believe that it does in this case since the provisions of Section 1.104-1, paragraph (d) of the Regulations do not specifically rule out the exclusion of disability insurance benefits.⁵ The one exception again is the business or professional overhead expense disability policy, under which the proceeds must be included in gross income. (Of course, when the benefits are used to pay overhead expenses, the expenses are deductible as business costs.)

The tax rules with respect to gains or losses on surrender values of key man life and health insurance are no different from the rules discussed in Chapter 17 in connection with personal insurance.⁶

Retaining the Key Man. Life insurance may be used to fund plans designed to attract and retain key employees. Several devices have been used for this purpose.

Deferred Compensation Plans. One method of compensating stockholder-employees, officers, and other key employees has received considerable

² This, of course, seems inconsistent with the decision in the *Emeloid* case, quoted earlier, which upheld the purchase of business insurance as being for an essential business purpose, and likened its purchase to the purchase of property insurance. Yet premiums paid by a business for property insurance are deductible, whereas those paid for life insurance are not.

³ Rev. Rul. 55-264, CB 1955-1, p. 11. This must be a specific overhead expense policy form. An ordinary loss-of-time policy will not qualify. [Rev. Rul. 59-480, CB 1958-2, 21.]

⁴ Cf. Section 104(a), *Internal Revenue Code* of 1954.

⁵ Cf. *Castner Garage, Ltd.*, 43 B.T.A.1.

⁶ As of this writing, only one company is offering health insurance with cash surrender values.

attention: deferred compensation. In qualified pension plans, employer's contributions to pension funds are deductible in the year made, whereas the employee does not have to report these contributions as income until the year payments are received, as developed in Chapter 14. It is sometimes desirable to grant to certain employees deferred compensation benefits beyond those included in the qualified plan. To try to include these benefits in the basic pension plan might disqualify it on the grounds that it discriminates against the lower-paid employees. Therefore, they must be handled on a supplementary basis. The problem is how to set up the supplementary plan.

Assume a key man with a salary of \$40,000 a year. At that time his tax brackets are high. After payment of taxes, his net take-home pay is much less. So he might get together with his company (or like to) and say:

How about paying me \$35,000 a year instead of \$40,000 a year for the next twenty years? At the end of that time, I'll retire, and you can pay me \$10,000 a year for ten years. Right now, I'm 45 years old. If you pay me \$40,000 a year for twenty years, that will total \$800,000. On the other hand, if you pay me \$35,000 a year for twenty years, then that total will be \$700,000, leaving a differential of \$100,000. I'll draw that \$100,000 by taking \$10,000 a year for ten years.⁷ In that way I'll reduce my income tax liability for the next twenty years, and when I retire at age 65, I'll be in the lower \$10,000 tax brackets and have more exemption. This will reduce the cost of financing my retirement to the extent of the tax savings effected.

The corporation could underwrite the future \$10,000 a year liability by buying a deferred annuity for the employee.

However, such a plan will not save the employee any taxes, because if he were entitled to draw \$40,000 instead of \$35,000, he would nevertheless pay income tax on the entire \$40,000 because of the "theory of constructive receipt," under which amounts that could be drawn at will are considered as actually paid.

Suppose, however, the employer says to the key man:

We should like to pay you a bonus, but we cannot afford to pay it now. We want you to be happy and satisfied with your earnings from this company, and we want you to stay with us. So here's what we'll do: We will continue to pay you your present salary, which is all we can afford right now, and we will promise you that when you retire twenty years from now, we will give you \$10,000 a year even though you are not actually working for us in an active capacity at that time.

In a case like this, since the employee was not entitled to receive the money immediately, the theory of constructive receipt apparently would not apply. This, then, would seem to be an opportunity to use life insurance to underwrite the future bonus: to assure the employee he would get it, and to provide the employer with the funds when the promise became due. How-

⁷ For the sake of simplicity, this illustration disregards the fact that the respective present values would not be equal.

ever, the widespread interest in such plans came to the attention of the Treasury Department. The Department has indicated that if an employee's right to future compensation is "nonforfeitable," the commuted value of the employer's promise to pay will be construed as taxable income in the year the promise is made. By "nonforfeitable" the Internal Revenue Service appears to mean no *if's*, *and's*, or *but's* attached to the employee's right to get the money in the future.

If, on the other hand, the corporation says to the employee: "If you continue to work for us until you reach age 65, we will pay you \$10,000 a year until your death *as long as you are not working for a competitor*," then vesting is *conditional* and not *absolute*. In that case a "constructive receipt" interpretation seems unlikely.

SETTING UP THE INSURANCE. Life insurance can be used to fund a deferred compensation plan. The policy should be taken by the employer on the life of the employee, with the employer as the beneficiary. The type of policy to be used depends upon whether the deferred compensation plan is to be tied in with a key man indemnification plan and whether the widow is to receive any benefits in the event of the death of the key man while he is still employed.⁸ If the plan creates a contingent liability for the employee only and ignores employee key man indemnification, an annual-premium deferred annuity will be sufficient. If the plan calls for a contingent obligation to the widow in the event the employee dies, an endowment at age 65 is required. If the plan does not include the widow but is to double as key man indemnification, then the policy should be a whole life of the type which provides the desired balance between the face amount needed at death for indemnification and the cash value needed to fund the employee's benefit at age 65.

In no case should the employee hold any incidents of ownership in the policy. The deferred compensation agreement and the insurance must be kept separate. The obligation of the employer to pay the deferred compensation benefits must be independent of the insurance. In fact, no reference should be made to the insurance in the employment agreement. The purpose of the insurance is to give the business added financial resources which will help it maintain a sound financial position in face of its potential liabilities. The reason for keeping the employment agreement and the insurance separate is income tax consequences. Without the separation there is a chance that the premiums paid by the employer will be considered current taxable income to the employee and thus defeat the purpose of deferred compensation.

THE TAX ASPECTS. Premiums paid by the employer for life insurance

⁸ Generally, it is better to eliminate the widow from the deferred compensation plan and cover her instead with the split-dollar plan to be discussed later. Income tax laws give preferential treatment to insurance proceeds payable by reason of death. Funds paid by employers to the widow of a deceased employee are subject to income tax after a one-time \$5,000 exemption. However, under practically every circumstance, no income tax is due on life insurance proceeds to the beneficiary.

for this purpose are not deductible. The cash values or endowment proceeds paid to the employer are taxed in the same way as they are in personal insurance.⁹ Proceeds paid at the death of an employee are not taxable. Deferred compensation paid to the employee or his widow are deductible as a business expense in the year paid. As for the employee, if the employment agreement is properly drawn,¹⁰ the employee incurs no tax liability prior to retirement and then only for the amounts actually received. If the plan guarantees payments to the widow upon the employee's death, the present value of these payments at the time of the employee's death must be included in his estate for estate tax purposes. The widow must report as income, for tax purposes, all amounts in excess of the first \$5,000. The widow, however, can deduct from these payments the amount of the estate tax paid on them.

\$5,000 Exemption. An employer may pay the widow (or estate) of a deceased employee up to \$5,000 after his death, and the widow (or estate) does not have to report the money as income for tax purposes. However, if the deceased employee had more than one employer, the exemption applies only to a total of \$5,000. His beneficiary can not claim an exemption for each \$5,000 paid by each employer. The employer, of course, can deduct the \$5,000 payment as a business expense. The employer can use the promise of a \$5,000 tax-free payment to the employee's widow to encourage him to remain on the job.

Life insurance may be used to fund these payments. The employer insures the life of the employee and names himself as beneficiary. Premiums are not deductible nor are proceeds reportable for income tax purposes. The employer gains a tax advantage when he collects the proceeds tax-free and deducts as an expense the amount paid over to the widow of the deceased employee.

The Split-Dollar Plan. The split-dollar plan has, as its primary use, tying junior executives to the company. Under this arrangement a policy with a cash value (whole life or endowment) is purchased by the employer on the life of the employee. The employer owns the policy, but the employee is given certain rights in it through an employment agreement. The annual premium is shared by the employer and employee. The employer's portion each year is that amount which equals the increase in the cash value. The employee pays the remainder. Since customarily the policy contains no cash value the first year, the employee pays the full first-year premium. As the cash value increases in subsequent years, the employee pays less and less until eventually, when the annual increase in cash value exceeds the annual premium, the employee pays nothing.

⁹ Cf. Chapter 17.

¹⁰ The employee must have no vested rights in the plan before reaching retirement age; severance of employment before reaching retirement age must cause the benefits to be forfeited; the benefits may be conditioned upon the employee's serving as a consultant after retirement or refraining from working for a competitor; and all benefits must be paid periodically and directly by the employer.

The agreement between the employer and employee provides that in the event of the death of the employee, the employee's beneficiary is entitled to the face of the policy less the cash values. The employer retains the cash values, which will always be equal at least to what the employer has paid. The maximum cost of the plan to the employer is the loss of interest, after taxes, on the money he has tied up in it. The advantage to the employee is the ability to purchase large amounts of life insurance at a cost which is less than a similar amount of insurance purchased on a decreasing term plan. If a participating policy is used and the policy contains the one-year term dividend option, the use of this option could preserve the full face amount of the policy for the employee's beneficiary during most of the life of the policy. Some companies have developed special policies for use under the split-dollar plan.

Table 37 illustrates the operation of the split-dollar plan when used in conjunction with the one-year term dividend option. The illustration is based on one company's dividend and premium scales in use at the present time. Except for the guaranteed values, actual results will depend on future experience.

As stated, the widest use of the plan is with junior executives whose present value to the company is relatively minor (in terms of salary) but whose future value as senior executives is considered great. The insurance is a fringe benefit that may help hold them with the company until they develop to senior executive capacity. The plan can also be used to fund the buy-and-sell agreement in a sole proprietorship (to be discussed later) in which younger men in the business may wish to buy out the proprietor's interest at his death or retirement.¹¹

Health Insurance for Key Men. In a company where little or no health insurance is given the employees on a group basis, the employer can use individual health insurance plans to attract or retain key men. These plans offer favorable tax treatment. Payments made by an employer to a disabled employee are not taxable to the employee if they satisfy one of the following conditions: (1) reimbursement for medical care, (2) payments for permanent injury or loss of bodily function, or (3) payments in lieu of wages during absence from work as a result of bodily injury or sickness. This latter condition has the following qualifications: (a) Payments for the first week of sickness are not excludable unless the employee has been hospitalized at least one day during the first week. This qualification does not apply to accidental injury. (b) The excludable amount is limited to \$100 a week.

Under a key man disability plan where the employer is the beneficiary, he may not deduct the premiums, but he probably¹² may receive the bene-

¹¹ It is also sometimes used by fathers to encourage sons to buy larger amounts of life insurance at earlier ages.

¹² Compare Section 101(a) of Code with Section 104(a)(3) and see also Section 1.104(d) and Rev. Rul. 58-90, IRB 1958-11, 12.

TABLE 37.

**Split-Dollar Plan Using One-Year
Term Dividend Option**

Year	Age 35				Plan Ordinary Life		Amount \$100,000		Annual Premium \$2,438	
	Guaranteed Cash Value End of Year (1)	Dividend at End of Previous Year (2)	Cost of One-Year Term Additions (3)	Acc Divs. Beg of Year After Purchase of Term (4)	Term Additions Purchased Beg of Year (5)	Combined Death Benefit ^a (6)	Increase in Combined Cash Value for Year ^b (7)	Premium Paid by Em- ployee (8)	Total Paid to Date by Em- ployee ^c (10)	Death Benefit for Em- ployee (6)-(10) (11)
1	\$ 200	\$ 0	\$ 0	\$ 0	\$ 0	\$100,000	\$ 200	\$ 200	\$ 200	\$ 99,800
2	2,100	263	6	257	2,100	102,357	2,157	2,157	2,357	100,000
3	4,100	311	13	563	4,100	104,663	2,306	2,306	4,663	100,000
4	6,000	360	20	921	6,000	106,921	2,258	2,258	6,921	100,000
5	8,000	408	28	1,331	8,000	109,331	2,410	2,410	9,331	100,000
6	9,900	457	38	1,793	9,900	111,693	2,362	2,362	11,693	100,000
7	11,900	499	50	2,300	11,900	114,200	2,507	2,438	14,131	100,069
8	14,000	542	63	2,854	14,000	116,854	2,654	2,438	16,569	100,285
9	16,000	584	78	3,453	16,000	119,453	2,599	2,438	19,007	100,446
10	18,100	627	95	4,097	18,100	122,197	2,744	2,438	21,445	100,752
15	27,600	825	219	7,930	27,600	135,530	2,737	2,438	33,635	101,895
20	37,200	1,011	453	12,451	37,200	149,651	2,832	2,438	45,825	103,826
25	46,600	1,184	877	16,912	46,600	163,512	2,630	2,438	58,015	105,497
30	55,700	1,341	1,617	19,822	55,700	175,522	2,157	2,157	69,740	105,782

^a Includes accumulated dividends. The death benefit will be increased by any post-mortem dividend payable and by interest on accumulated dividends from the preceding policy anniversary to the date of death

^b Increase in guaranteed cash value for the year plus increase in accumulated dividends at the beginning of the year

^c Death benefit for employer is equal to total paid to date by employer

Note: The forty-second policy year is the last year for which the accumulated dividend fund is sufficient to purchase one-year term additions equal to the full guaranteed cash value under this policy.

fits without tax liability, place them in his general funds, use them to fund salary-continuation payments to the employee, and deduct these payments as a business expense. The employer, of course, may retain a part of the proceeds as indemnity for loss of the services of the key man.

Another arrangement is to have the benefits paid directly to the key man. In these cases, premiums paid by the employer are deductible as a business expense under Section 162 of the Code, provided they are in consideration of personal services actually rendered by the employee, and do not constitute unreasonable compensation for services performed¹³

Section 106 of the Internal Revenue Code states that premiums paid by the employer are not taxable income to the employee.

2. SOLE PROPRIETORSHIP INSURANCE.

The predominant type of business structure in the United States and Canada is the sole proprietorship, under which one man owns the business alone, without partners or shareholders. From the standpoint of estate planning, it is one of the most dangerous of all types of business structures. Rarely, however, does the sole proprietor realize this fact.

Ask the corner grocer, druggist, or garage-owner where the family support would come from if he were to die or become disabled. His answer nearly always will be, "The business will provide an income." In many cases the business not only will fail to provide an income, but it may also be an expense to the family and cut deeply into other available estate assets.

The Problem in Sole Proprietorships. The estate problem in the sole proprietorship organization arises from the fact that *the law recognizes no difference between the business and the personal estate.*

The sole proprietor, however, usually thinks of his business as something apart from his personal estate. He thinks of the business as his "job," the source of income for his family needs and out of which he accumulates such property as a home, a car, a savings account, and perhaps securities or other investments of a "personal" nature not connected with the business.

Actually, his business and personal estate—the home, the car, the savings account—are one and the same thing. His business assets can be attached to pay his personal debts, and his personal assets can be attached to pay his business debts. They are interchangeable. Many are the cases in which errors in business judgment have caused losses of personal fortunes as well as instances in which extravagances in personal living have caused losses to business estates.

When a Sole Proprietor Is Disabled. In most cases the sole proprietor is not only the owner and manager of the business, he is also a full-time employee. Therefore, when he becomes disabled, the business is without the

¹³ Cf. Revenue Ruling 58-90, *Internal Revenue Bulletin* 1958-11, p. 12. However, where the key man is also a stockholder, the premiums may not constitute a deductible expense. Note that the cited ruling uses an example in which it is stipulated that the employee is not a stockholder.

services of a key employee. If the disability is of lengthy duration, his services will need to be replaced.

One of two solutions is usual:

(1) Someone from the family steps in and does his work: his wife, perhaps. This, however, might not be satisfactory. If his disability is such that he cannot work, he might need full-time care at home. If his wife has to run the business, then she must hire someone to take care of the house. This will create an added drain on the family budget. It also is likely that the wife will not be capable of performing his job as efficiently as he did. The probable result is that the income will drop, while, at the same time, expenses will increase.

(2) A manager is hired. His salary will have to come directly out of profits, thus reducing the income to the family by a like amount. Further, unless the manager is as efficient as the proprietor, the income from the business will drop. If he is as efficient, he will be entitled to, and probably will demand, a high salary. In the case of many sole proprietorships, the business provides only one good income: that of the owner-manager. If a non-owner-manager also must be paid a good income, what is left for the owner?

Disability income insurance on the sole proprietor can be used to help offset the financial problems involved in each of the above courses of action.

If the proprietor's wife is capable of running the business, then there will be additional income to pay for the cost of her replacement in the home. If she is not capable of maintaining the level of business profits, the disability income insurance will help to offset the drop in family income.

If a manager must be hired (or an existing employee promoted to the position of manager), the disability income insurance will provide a fund which can be used to pay the additional costs of business management and to cushion a possible decline in profits resulting from the change in management. Inasmuch as disability insurance purchased on the proprietor is personal insurance,¹⁴ proceeds from it will be income tax free. Therefore, the amount of insured income needed will be less than the amount of gross income to be offset.

Short-term disability¹⁵ of the owner which produces inconvenience in

¹⁴ Since the business and personal estate of a sole proprietor are one and the same, any sole proprietorship insurance is, in the final analysis, personal insurance. However, the existence of the business creates new insurance needs, a different viewpoint on the part of the insurance buyer, and a different basis for the evaluation of insurable needs. Hence, it seems valid to classify sole proprietorship as "business insurance" even though there is no business ownership as encountered in some other forms of business insurance.

¹⁵ What constitutes a "short-term" disability in such a case depends on how long the business could get along without the services of the proprietor without either (1) incurring additional expense for someone to perform his duties or (2) causing a serious drop in profits. In a one-man business, cost or loss might start almost immediately. When the total of that cost or loss mounts to a point which will be a financial hardship (as contrasted to inconvenience), then insurance should be available. In a larger proprietorship with a number of employees, it might be several months before the absence of the proprietor would have serious financial effects. The elimination period in the coverage is, then, a matter of the individual case involved.

the business but no serious financial loss to the business is not a subject for business insurance. The discussion above refers to disabilities of durations long enough to create a major financial problem.

If the disability is permanent, there should be sufficient coverage to enable the sole proprietor to dispose of the business. He might wish to sell the business to an outsider or, if he has a son, he might wish to continue the business until his son is ready to take over. Sole proprietorship disability insurance will enable him to (1) take his time in making a sale so that he can gain the most advantageous price, in contrast to a distress sale, (2) enable him to keep the business until his son is old enough and experienced enough to manage it.

When a Sole Proprietor Dies. When a sole proprietor dies, the business does not pass immediately to his heirs or devisees. It becomes a part of his estate, to be disposed of by the executor or administrator. Actually, one of two things will happen: the executor¹⁶ will sell or liquidate the business, or the executor will make an effort to operate the business

(1) The executor will dispose of the business. Unless (a) the last will and testament of the sole proprietor contains express instructions "in direct, explicit, and unequivocal language" for continuing the business,¹⁷ or (b) all the heirs are adults and agree to assume the responsibilities for the continuation of the business, the legal duty of the executor is to dispose of the business as rapidly as possible. He has no choice in the matter, because he has no right to leave the estate assets invested "in trade"¹⁸ any longer than absolutely necessary. If he continues to operate the business beyond the time necessary for its sale or liquidation, he may be held personally responsible to the heirs for any loss.

Exactly how long an executor may leave estate assets in the business is a matter to be determined by the court in any given case. The executor, however, because of his exposure to liability, will tend to dispose of the business as quickly as possible. The sale, being a forced sale, will not be conducive to a favorable price. In any event, however, the amount realized from the disposal of the business asset is apt to be much less than the sole proprietor had expected. It is entirely possible that the liquidation losses will be so severe that the business estate will be inadequate to pay its own settlement costs. If this proves to be the case, then other estate assets will have to be used for this purpose: the bank account, the home, and, in some cases, family life insurance.¹⁹

¹⁶ Although there is a distinction between an *administrator* and an *executor* (cf. Chapter 17) the term *executor* will be used herein to mean either one.

¹⁷ Thompson on "Wills," Section 142-43.

¹⁸ Cf. 24 *Corpus Juris* 55, Section 474-75.

¹⁹ If the family's personal life insurance is made payable to named beneficiaries, it usually will not be subject to the claims of the insured's creditors. If it is made payable to the insured's estate, then it becomes a part of the estate and can be used to pay estate debts. Cf. Chapter 8.

The first need of the sole proprietor, then, is to protect his general estate against the debts of the business. He should provide enough cash through life insurance payable to his estate to meet all the business debts and estate administration costs without forcing liquidation of his so-called "personal assets."

(2) The executor will make an effort to operate the business. If there is an express provision²⁰ in the will permitting the executor to operate the business, the executor may attempt to run it. Before he can do this, however, there must be enough cash available in the estate to pay estate debts, administration costs, and estate taxes, or the business might have to be liquidated for that purpose. It should be held in mind, also, that the existence of an authorization to continue the business is not a mandate to the executor. If he undertakes to operate the business, the courts will take the position that the decision was voluntary on his part and hold him personally liable for all debts incurred by him in the operation of the business.²¹ If continuation of the business has been authorized, he is entitled to indemnification for any of these debts out of the general estate or out of any assets specifically earmarked in the will for the conduct of the business. However, should the newly created business debts exceed available estate assets, the executor would have to pay the excess without indemnification. A cautious executor will be hesitant, therefore, to operate the business, even when specifically authorized to do so.

How successful the executor's operation of the business will be, also is problematical. The nature of the sole proprietorship is such that much of its value as a going business is traceable to the proprietor himself. The business is successful because the proprietor himself made it that way. (Had there been others in the business equally responsible for its success, the business undoubtedly would have been organized as a partnership or a corporation.) The executor, however, rarely will be as effective in the management of the business as was the owner. Not only will he be less experienced in that particular business operation, but also he probably will have his own work to look after so that he will be able to devote only part-time to his duties as executor. People who traded with the business because of the good will created by the proprietor are likely to drift away, and suppliers may be hesitant to ex-

²⁰ A typical provision might read. "I authorize my executors for the time being to carry on, during such period as they shall think fit, the trade or business of _____, now carried on by me, and for that purpose to retain and employ therein the capital which shall at my death be employed therein, and such additional capital as they shall think fit to advance from time to time out of my residuary estate, with power to employ at such salary as they shall think fit, any manager of the said business, and generally to act in all matters relating to the said business as if they were beneficially entitled thereto; and my executors shall be free from all responsibility for losses arising in the prosecution of the said business." Quoted from *The R & R Advanced Underwriting & Estate Planning Service*, Vol Two, p 13-3. Copyright by the Research and Review Service, Indianapolis.

²¹ Cf. *11 Ruling Case Law*, Section 147.

tend additional credit. Creditors may demand immediate payment of all debts, a right they have upon the death of the sole proprietor, irrespective of the maturity date of the obligations.

Too often the continuation of the business by the executor results in a nightmare for the executor himself, accompanied by a steady reduction of business so that in the end he is forced to liquidate it anyway—and in view of the decline of the business, perhaps for even less than if the business had been liquidated immediately.

The need for sole proprietorship life insurance for business continuation (as distinguished from business liquidation) is to provide enough cash (a) to guarantee that the business will not have to be liquidated to raise cash for administration costs, debts, and taxes; (b) to provide the executor with working capital to carry on the business;²² and (c) to guarantee sufficient assets to indemnify the executor for debts contracted in running the business.²³

If the Business Passes to the Heirs. If, as a result of successful planning and a fortunate selection of an executor, the business does survive to pass to the heirs, sole proprietorship insurance can be of additional use:

(1) If the business passes to someone who will not be the active manager, such as the widow, an inexperienced son or daughter, or heirs who already are engaged in activities which are more attractive to them than the business, a manager will need to be hired. As already mentioned, the cost of hiring a manager can cut deeply into the profits of the business. If this will be the case, it may be better to dispose of the business and invest the proceeds in assets yielding a better net return. If, however, for some reason there is a desire to continue the business (for example, to preserve it for a minor son), and the business income is insufficient to pay a manager's salary, life insurance can be used to provide the funds. Actually, however, no business unable to support an adequate managerial salary should be continued except under unusual circumstances. A sole proprietor engaged in such a business needs personal insurance to offset the loss of his own personal earning power, since a high proportion of his income actually results from his personal services rather than from the capital invested in the enterprise.

(2) If the heir does take over active management, he or she may not be able to earn as much from the business for the first few years, at least, as was earned by the deceased proprietor. Sole proprietorship life insurance can make up the loss. Also, the insurance proceeds will be useful in helping the heirs maintain the credit rating of the business and retain its employees.

Actually, the advisability of turning over a sole proprietorship to the heirs to be held as income property is open to serious question. If the heirs are unsuccessful in operating the business, they may dissipate their in-

²² To offset the possibility of more stringent credit conditions.

²³ So as to reduce or eliminate the possibility of personal loss to the executor.

heritance from the general estate in an attempt to save the business. In this event, the business becomes a liability rather than an income-producing asset. Therefore, many sole proprietors recognize from the start that the most desirable plan of handling their business in event of death or permanent disability is to dispose of it.

If the Business Is to Be Sold. If the proprietor makes up his mind that disposal of the business is the best method of handling the estate problem relating to it, he may either (1) leave the disposal problem to the executor after his death or to the family in case of his disability, or (2) arrange for his own buyer in advance. In either case, sole proprietorship insurance is needed.

If the buyer is to be located after disability or death occurs, the proprietor should recognize two facts:

(a) It will take time to arrange a favorable sale. In the meantime, cash will be needed to keep the business going and retain customers and good will until a buyer is located. Customers and good will usually make up a good part of the value of a sole proprietorship. A going business is worth more than the liquidation value of its inventory and equipment. Life and disability income insurance can provide the needed cash to continue the business in operation and to preserve its values until it is sold.

(b) No matter how competent the effort to maintain the value of the business after the loss of the owner, that value is almost certain to decline. As has been said, the sole proprietor himself is one of the most important sources of value in the business. When he is forced to disassociate himself from the business because of disability or death, the value of the business is almost certain to decline. In estimating the value of his estate, the sole proprietor, therefore, must take this probable shrinkage into consideration and, if necessary, offset it with additional insurance protection so that his estate will continue to provide the income necessary for the maintenance of his family.

If the proprietor decides to arrange for a buyer in advance, the problem of finding the buyer after disability or death will be eliminated, but two new ones will be introduced: first, assurance that the buyer will go through with the purchase, and second, guaranteeing that the buyer will have the money to pay the agreed upon price.

The first problem is a matter of contract. A contractual agreement can be drawn up under which the proprietor agrees to sell and the buyer agrees to purchase the business at a price to be determined by the agreement.

The second problem is a matter of sole proprietorship insurance.

In its simplest form, the sole proprietorship buy-and-sell arrangement contemplates that insurance on the proprietor will be bought and paid for by the prospective purchaser of the business. If the buyer is not able to finance the premiums necessary to purchase all the insurance needed, provision may be made in the agreement for the insurance proceeds to be used

as a down payment, with the remainder of the purchase price, as fixed by the agreement, to be paid over a period of years out of the income from the business. If the proprietor wants his family to have a fixed sum in cash immediately upon his death and that sum involves more insurance than the buyer can afford, the proprietor may arrange to advance part of the necessary premiums, to be paid back by the buyer in addition to the purchase price.²⁴

When sole proprietorship life insurance involves post-mortem purchase of the business under a buy-and-sell agreement, a trust may prove advantageous. Proceeds of the policies are paid into the trust, and the trustee handles all details of the transfer. The trust arrangement is more flexible and less complicated than paying the proceeds to the buyer who, in turn, must deal with the executor in effecting the transfer. For one thing, the executor will have a prejudicial interest in the transaction (the interest of the estate), whereas the trustee is likely to be impartial, interested in neither the buyer nor the seller, but only in carrying out the terms of the agreement.

A disability income plus waiver-of-premium rider on the sole proprietorship life insurance can also be used to help fund the buy-out agreement. For instance, assume a \$50,000 sole proprietor life insurance policy taken at age 45 on a continuous-premium whole life basis with a disability income and waiver-of-premium rider. The non-par or net-after-dividend premium for such a policy in one company would be about \$1,800 a year. In case of the disability of the sole proprietor as defined in the rider²⁵ and agreement to sell the business in such event, he will receive \$10 per month per \$1,000 of face amount—or \$500 a month income—and the potential buyer has \$1,800 a year waived in premiums that can be applied on the purchase price. If disability income coverage is not available as a rider to the sole proprietorship life insurance, or if income before the end of the waiting period specified in the rider is advisable, a specific disability income policy may be purchased.

If the disability income payments plus the waived premiums are inadequate to pay the purchase price over a reasonable length of time, the payments can be supplemented out of business income. Since disability income insurance does not pay off in lump sums,²⁶ the terms of payment in

²⁴ It is sometimes contended that if the proprietor must advance part of the premiums to the prospective buyer, he might be better off to use the money to buy personal insurance and have, at his death, the insurance *and* the business. Actually, each estate problem must be studied individually to determine the best solution for the objectives involved. Often the principal problem is to get the business out of the estate. Otherwise, its debts or deficit operation may drain the general estate, since the two are legally one and the same. Personal insurance does not assure that this will be done.

²⁵ Usually defined as "total and permanent"; however, case law has so altered the definition commonly used in such riders that despite the rider language, it amounts to total disability with a waiting period. Usually, also, disability must occur before some such age as 55 or 60—55 in the policy quoted.

²⁶ Except for disability from dismemberment or loss of sight, for which capital sum coverage is available.

the buy-and-sell agreement should not require a large down payment. The buyer might be able to raise a small down payment out of his own resources or through a loan.²⁷

The continuous-premium whole life form with waiver of premium and monthly income disability is ideal to fund a buy-and-sell agreement. In case of death the proceeds of the life insurance will provide the buyer with the cash to complete the purchase. In case of disability the monthly income will provide funds for the periodic payments, and the waiver of premium will continue the values of the policy, which will be available at death to complete the payments, or at an earlier date should the cash values of the policy equal the balance outstanding on the purchase price. The loan value could be borrowed at that time and turned over to the seller. Since the waiver of premium will keep the policy in force, the policy loan will never have to be repaid. Interest paid on the loan will be deductible as an expense for income tax purposes. The disability income will continue to be paid, and the owner of the policy will collect the death or endowment benefits, less the policy loan, when they mature.

Such buy-and-sell arrangements in sole proprietorships most often are made between the proprietor and a key employee or employees. When so made, they tie the employees closer to the business and help to eliminate turnover among key employees.

Occasionally, the best solution to the problem of the disposition of the business is incorporation. Such a situation might arise where there is a minor child and the proprietor wishes to hold the business for him. If there is a key employee in the business capable of running it, a solution would be to incorporate the business upon the death or disability of the proprietor, selling the key employee a portion of the stock and placing control of the business in a trust until the child reaches an age at which he is capable of handling it himself. If disability rather than death causes the sale, and the proprietor can comprehend what is going on, he might retain the stock and vote it himself.

3. PARTNERSHIP INSURANCE.

Corpus Juris defines a business partnership as "a contract of two or more competent persons, to place their money, effects, labor and skill, or some or all of them, in lawful commerce or business, and to divide the profit and bear the loss, in certain proportions."²⁸

Two principles should be held in mind with respect to the partnership: (1) Each partner in a general partnership (the most common type) is fully liable for all debts and obligations of the firm to the extent of his personal estate, and (2) at the death of a partner, the firm, in the absence of an agreement to the contrary, is legally terminated as to future business ir-

²⁷ The loan can be made against the business assets or against the cash values of the life insurance written to fund the agreement in case of death.

²⁸ 47, 640, Section 1.

respective of the desires of the surviving partners.²⁹ Business problems can arise out of the disability or death of a partner, and life and health insurance can be of help in solving these problems.

When a Partner Is Disabled. Except in the case of a "silent" partner, disability of a partner deprives the firm of a key employee. If he is disabled for a long period of time, it will be necessary to hire someone to do his work. In the case of a personal-service partnership, the income of the firm may be reduced by the amount of business lost because of the inability of the disabled partner to handle it.³⁰ At the same time, the disabled man is entitled to his division of the partnership profits and, perhaps, a continuation of his so-called "salary" or drawing account. It is possible to draw the partnership agreement so that any partner's share of the firm income is in proportion to his active contribution to it. However, the partnership arrangement usually grows out of and cultivates a close personal relationship among the members of the firm. The chances are that even if partners are not contractually bound to continue income to a disabled partner, they will feel morally obligated to do so. As a result, the income of all partners will be reduced.

Such loss of income can be avoided by the use of partnership disability insurance under which each partner carries disability income insurance and agrees to eliminate or reduce his drawing account in case of disability.

When a Partner Dies. The partnership relation is a personal one. It subjects each partner to responsibility for the acts of the other or others. Because it is such a close relationship, the law protects the right of a person to select his partners. No one can choose a partner for another, nor can anyone elect to be the partner of another unless the other is willing. The entire act of effecting a partnership is *voluntary*. Therefore, unless there is an agreement or a statute to the contrary, the death of a partner dissolves (except as noted in footnote No. 29) the partnership and leaves each surviving partner free to choose new associates.

The business must be either *liquidated* or *reorganized*, and the choice is not entirely up to the surviving partners. The law provides only for liquidation, except where the heirs of the deceased partner may agree to permit their inherited share of the business to remain in the partnership,³¹ in which case they become partners. If the heirs are minors, if they are unwilling to join the firm, or if the surviving partners do not want them as new partners,

²⁹ It is sometimes stated that the death of a partner *terminates* the partnership. In the legal sense of the term "terminate," it does not. After dissolution, a partnership remains as a firm as long as is necessary to wind up pre-existing obligations. However, dissolution—which is effected whenever a partner withdraws as well as when one dies—operates with respect to all future business transactions. A dissolved partnership may not take on new business commitments.

³⁰ Some of the business attracted to the firm because of any given partner, of course, will continue and can be handled by one of the other partners.

³¹ 20 *Ruling Case Law* 990, Section 226.

liquidation usually is the only choice in absence of a partnership buy-and-sell agreement.

If liquidation is necessary, the surviving partners become trustees in liquidation, saddled with the responsibility of trusteeship, bound to act promptly and honestly and to render an accounting of their acts to the personal representatives (executors or administrators) of the deceased.³²

Forced liquidation is an unfortunate solution, for rarely will the full value of the assets of the business be realized. The surviving partners may find themselves without a business or jobs. Business debts that cannot be paid from funds realized from the sale of the business assets can cut into the personal funds of the surviving partners and the estate of the deceased. Since the estate can be held liable for the entire debt of the partnership, the heirs of the deceased may not only fail to realize anything from the business but also may find other estate assets depleted because of the business.

So, if for some reason it is decided that upon the death of a partner the business shall be liquidated instead of reorganized, sufficient life insurance on each partner will be needed to offset liquidation losses and to protect the other assets of the surviving partners and those of the deceased partner's estate against the debts of the business.

If the firm is to be reorganized,³³ four courses are open:

(1) The surviving partner or partners may be named heir or heirs of the deceased.

(2) The survivors may take in the heirs of the deceased as partners.

(3) The survivors may agree to take in as a partner, purchasers of the heir's interest.

(4) The survivors may purchase the interest of the heirs.³⁴

(1) *Inheriting the Share of the Deceased.* Obviously, partners will name each other as heirs only where the survivor is a person to whom the deceased partner normally would make a bequest, as in father-and-son partnerships. In these arrangements, unless the son also makes his father heir to his interest, a problem will result if the son predeceases his father. It is more customary for the father to leave his interest to the son, but for the son to pass his interest to his wife. Arrangements, therefore, should be made in the son's will to handle the son's interest in case he predeceases his father. In partnership estate planning, it is too often forgotten that fathers sometimes do bury sons.

(2) *Taking in the Heirs of the Deceased as Partners.* As previously

³² For a description of the role of the survivors as trustees, cf. *40 American Jurisprudence*, Section 306.

³³ Reorganization will nearly always be the desire of the surviving partners, whose jobs as well as money are tied up in the firm.

³⁴ Actually there is a fifth method of reorganization: the heirs may buy out the partners. Usually, however, the survivors will not be interested in this method of reorganization since it leaves them without a business; and rarely will the heirs want the business.

mentioned, the nature of the partnership relationship is close and personal. The surviving partners wish to select their own partners. It would be unusual if the heirs had the same qualities that made the deceased partner attractive to the survivors. Further, the heirs rarely will want to go into the firm as active partners. Usually they have no experience in the business and no interest in working in it. They might be a little more willing to be "silent" partners (i.e., nonworking partners), but the surviving partners may not be able or willing to support nonworking partners. Usually, the survivors do not want new partners and the heirs do not want an interest in a partnership. They want money.

(3) *Taking in the Purchaser of the Heirs' Interest as a Partner.* The survivors are under no obligation to take in as a partner a prospective purchaser of the heirs' interest. Although occasionally the surviving partners and heirs may be able to agree on a purchaser, it is poor estate and business planning to leave the disposition of the interest of the deceased partner to a chance sale agreement.

(4) *Purchasing the Interest of the Heirs.* In most cases the only satisfactory method of reorganization is for the surviving partner or partners to purchase the interests of the heirs. The problems involved here are (a) reaching an agreement with the heirs as to the terms of the purchase and (b) financing the purchase.

Reaching an agreement as to terms will prove no simple matter in the majority of cases. In the first place, the survivors will have to deal with an executor who is under obligation to obtain the best "deal" possible for the heirs. Usually, therefore, he will set a high price. If his asking price is refused, he has evidence that the interest of the heirs is not worth as much as they expected. If he compromises, the heirs may feel he made unnecessary concessions. In the second place, it is difficult for the heirs to realize that the business without the services of the deceased is worth less than it was while he was still alive. They tend to think of the value of the share in terms of what the deceased had earned from it. If he has been realizing \$20,000 a year out of the business, they tend to think of the \$20,000 as business profit, ignoring the value of the personal services he rendered to the firm. Since \$20,000 a year is a return on \$200,000 at, say, 10 per cent (a reasonable capitalization percentage for the business involved), they think of the value of his share in terms of that figure; whereas the entire assets of the firm, and even its value as a going business, may be only a fraction of that amount.

Often the attempt to buy out the heirs *after* the death of a partner results in a stalemate over price that can be resolved only by liquidation; and liquidation is rarely to the gain of either the survivors or the heirs.

The solution is an advance agreement on the part of each of the partners that in the event of the death of one partner, the survivors shall have a right to acquire the deceased's interest and are obligated to purchase it at a price set in the agreement or determined by a formula established in the agreement. This is the partnership buy-and-sell agreement.

Disability of a partner can also be covered with a buy-and-sell agreement.³⁵ One method is to agree that each partner will carry disability income insurance on his own life and that during an initial period of disability as defined in the policy (say two or three years), he will receive a gradually decreasing income from the partnership itself. If the disability continues beyond the initial period, the other partner or partners will then buy out his interest in installments, the transfer of interest to be effected by making out to him a series of notes, payable, say, over a seventy-two-month period. Alternatively, the arrangement might be to convert a permanently disabled partner into a "silent" partner. Assuming there is also partnership life insurance, each partner may be given the option of purchasing the policy on his life held by the disabled partner—but until such purchase is made and paid for, the disabled partner must maintain the life insurance in force (although a time limit for the exercise of purchase option may be set). A partnership entity plan and cross-purchase (both to be discussed shortly) are also possible.³⁶

In the case of death buy-out agreements, two types are possible: the *survivorship* agreement and the *purchase* agreement.

The *survivorship* agreement provides that upon the death of a partner, his interest shall vest in and become the property of the surviving partners, either at his death or upon the payment of a stated amount. Since this type of agreement makes a direct transfer, it might be challenged as an attempt to make a testamentary distribution of property outside of a will.³⁷

The *purchase* buy-and-sell agreement uses the language of purchase and sale. Each partner agrees that if he dies, his estate will sell his partnership interest at the price and terms set in the agreement. He also agrees that if he is predeceased by any other partner, he will purchase his pro rata share of the interest of the deceased. The agreement provides that the deceased's personal representative (executor or administrator) will make the necessary

³⁵ There is at least one dissenting opinion R. W. Hulgadag, in "Should Disability Be Covered in the Buy-Out Agreement," *The Insurance Salesman*, July, 1957, p. 55, argues that the treatment of the disability of a partner should be covered in the articles of partnership, not a buy-and-sell agreement: "Disability insurance—vital to the partnership or close corporation—should be in the form of what is loosely called key man rather than buy-out." This position has been directly attacked by William Harmelin and Morris Friedman, *Disability Insurance in the Business Buy-Out Agreement* (Rough Notes Company, Indianapolis, 1958).

³⁶ For a discussion of the tax considerations involved in various types of disability buy-out agreements for partnerships, cf. William Harmelin and Morris Friedman, *Disability Insurance in the Business Buy-Out Agreement* (Rough Notes Co., Indianapolis, 1958), and Hugh M. MacKay, "Disability, Retirement or Death of a Partner," *The Journal of CLU* (American Society of Chartered Life Underwriters, Philadelphia), Vol. XIII, No. 1, Winter, 1958, p. 53ff.

³⁷ Most of the litigation concerning the legality of buy-and-sell agreements has been over the survivorship type. The preponderance of opinion has upheld its legality, starting with *McKinnon v. McKinnon*, 56 Fed. 409 (1893). There has been some contrary opinion, for example, cf. *Ferrara v. Russo*, 40 Rhode Island 533, 102 A. 86 (1917) or *Gomez v. Higgins*, 130 Alabama 493, 30 S. 417 (1900).

transfers. The legality of this type of agreement has seldom been successfully challenged.³⁸

The funded buy-and-sell agreement offers a planned solution to the problem of disposal of a partnership interest. The price is established in advance by a formula which is likely to be equitable, since it was determined by the partners under the most favorable conditions for achieving equity: The parties, in making the agreement, do not know on which side of the transaction they will find themselves when it is carried out. If they survive, they are the buyers; if they die, they are the sellers.

The agreement guarantees that the heirs will sell and that the surviving partners will buy the interest of the deceased partner. The only problem that remains is whether the buyers will have the money to carry out the agreement. The certainty of a buy-and-sell agreement loses its effectiveness if it is not funded, i.e., if no funds are arranged in advance to meet the obligation.

While there may be other methods of funding a buy-and-sell agreement, insurance will almost always prove the best solution. The situation which creates the need for funds—death or disability—also creates the funds needed. The insurance proceeds. If insurance is used to fund the agreement, the partners will not have to drain their personal resources, nor will they have to borrow to carry out the terms of the agreement. Partnership insurance provides the amount of money needed,³⁹ at exactly the time it is needed, and on the most efficient basis.

How the Insurance Is Arranged. The insurance to fund the buy-and-sell agreement can be arranged in several ways. The most popular plans are the *cross-purchase* and the *partnership entity*.

The Cross-Purchase Plan. Under the cross-purchase plan, each partner individually buys and maintains enough insurance on the lives of the other partners to fund the purchase for which he is obligated.

The cross-purchase plan has a number of advantages; among them:

(1) Since each partner owns and pays the premiums on the policies on the lives of the others, he pays exactly in proportion to his benefits.

(2) The plan may be free from estate tax complications, since the deceased may hold none of the incidents of ownership in the policy on his life.

³⁸ An instrument that is testamentary in character operates only by reason of the death of the maker. The instrument of a purchase-type buy-and-sell agreement is operative the day it is signed. The element of present existing contractual rights distinguishes this type of agreement from the survivorship type. Cf. *Ireland v. Lester*, 298 Mich. 154, 298 N.W. 488 (1941).

³⁹ It is not necessary for the insurance to equal the full amount of the value of the deceased's share. In fact, where the price is to be set by a formula taking into account current financial factors, it is impossible to have the life insurance equal the exact amount, for that amount is unknown until after the death of a partner. If the full amount cannot be insured, the life insurance can be considered a down payment, with the balance to be paid under arrangements set forth in the agreement.

(3) The purchase price sets the cost basis for the income tax of the share purchased in case of its later sale.

(4) The plan is more flexible since, in the case of more than two partners, the survivor may purchase any amount of the deceased's share agreed upon rather than an amount which is in direct proportion to his share in the partnership. For instance, among three equal partners, one might wish to purchase only 25 per cent of the interest of a deceased partner, leaving the other 75 per cent to the other surviving partner. Under a cross-purchase plan in which each partner is acting as an individual buyer, this arrangement can be made.

The fact that one of the partners may be much older than another sometimes is considered a disadvantage of the cross-purchase plan, under which each pays the premiums on the life of the others.⁴⁰ The older man in such a case is paying a lower premium than the younger man. This arrangement, however, is not inequitable, since according to the laws of probability, the younger men are more likely to collect on the policies they have purchased.

The one serious disadvantage of the cross-purchase plan arises when there are a number of partners. Only two policies are necessary when there are only two partners. If there are three partners, six policies are necessary. A four-man partnership requires twelve policies. If there are ten partners, ninety individual policies will be necessary. For this reason and others,⁴¹ where a partnership is composed of a large number of partners, the entity-purchase plan is most common.⁴²

The Entity Plan. Under entity plan the buy-and-sell agreement specifies that upon the death of a partner, the partnership itself will purchase the share of the deceased partner for the account of the surviving partners. The insurance on the life of each partner is owned by and made payable to the partnership. The partnership pays the premiums out of partnership income.⁴³ The cash values are carried as assets of the firm.

⁴⁰ Where there is a wide difference in age and proportionate ownership shares, it may sometimes prove impossible for younger members of the firm to pay the premiums on policies on older members directly, as under the cross-purchase plan. In that case premiums may be pooled either each partner contributes to the pool in proportion to his ownership interest or the total premiums are divided by the number of partners, each paying an equal amount. The buy-and-sell agreement should arrange, when necessary, for the reimbursement of the estate of the deceased for his premium contributions. Except under peculiar circumstances, the entity plan, to be discussed later, usually will prove a better way of meeting the problem of excessive premiums for some partners.

⁴¹ One of the "others" being that the sale of the cross-purchase plan calls for convincing each partner that he should spend money out of his pocket for premiums on insurance on the other partners. It is easier to sell a man on spending "company money," even when "company money" in the case of a partnership is actually the individual partner's money.

⁴² A variation of the individual ownership cross-purchase plan is the joint ownership plan under which the policies on the lives of the individual partners are jointly owned by the other partners who pay the premiums jointly and are the joint beneficiaries.

⁴³ The premiums, of course, are *not* deductible as a necessary business expense for income tax purposes.

The following points regarding the entity plan will be useful as a basis for comparing it with the cross-purchase plan:

(1) The indirect but real premium burden of the plan will rest more heavily on the larger-interest partners in contrast to those with smaller interests. An inequity is also created against the older partners in favor of the younger partners. While these features often make the plan more acceptable to those with smaller interests and to younger firm members, who usually are less able to pay the higher premiums required under the cross-purchase plan, they do require an adjustment in setting the purchase price for the shares of the larger interest and of the older firm members.

(2) The policies and proceeds are company assets and, as such, are subject to the claims of creditors of the firm. Thus, payment of the funds intended for the purchase of the share of a deceased partner could be delayed or the amount depleted entirely.⁴⁴ Of course, in the other plan, the proceeds are subject to the claims of the creditors of the individual partners.

(3) The result of the payment of the premiums by the firm is exactly the same as though each partner had paid them in direct ratio to his interest in the partnership. Under the cross-purchase plan, each partner owns the cash values in the policies he has purchased on the lives of the other partners, under the entity plan, the cash values are owned by the partnership. Therefore, in setting the purchase price for a deceased partner's share, the formula must take into account both the cash values of the insurance owned on the lives of the surviving partners and the proceeds of the policy on the life of the deceased partner.

(4) The deceased's interest in the firm will be divided among survivors in exact proportion to their present interests, which may be an advantage or disadvantage.

Who Shall Be the Beneficiary? In the cross-purchase plan, the *surviving partners* usually are the beneficiaries, since they are the ones obligated by the agreement to buy the interest of the deceased. Under the entity plan, *the partnership itself* usually is the beneficiary, since it is the party obligated by the agreement to purchase the deceased's interest.

In either type of plan, *a trustee as beneficiary* will usually prove the most advantageous arrangement. The trustee receives the proceeds, turns the money over to the personal representative of the deceased, and secures the necessary transfers and releases. Not only does the trustee plan provide for impartiality and relieve the survivors of the details of direct negotiations, but it also permits clear segregation of the partnership insurance proceeds from the proceeds of the personal life insurance carried by the deceased. As another function, the trustee can also serve during the life of the agree-

⁴⁴ If the financial situation of the firm is such that its assets are insufficient without the insurance, the insurance proceeds can be helpful in preventing the partners from being saddled with a personal liability for firm debts. (It must be remembered that a general partner has unlimited liability for the debts of the partnership.)

ment for certain details such as collection and payment of premiums and as a depository for the policies.

It is possible for the *estate of the insured* to be the beneficiary, although such a plan has its dangers because the executor or administrator then has in his hands both the insurance proceeds and the partnership share. Unless the agreement is legally binding, the executor may seek to retain both.

It is possible to make the policy payable to the *widow or other named beneficiary* of the insured. This plan is often considered desirable by partners who wish to give their beneficiaries the advantage of the installment options in the policy or to avoid the expense and delays of having the proceeds go through their estate, as they will have to go if paid to other than the insured's beneficiary. This plan also is fraught with dangers. The beneficiary might claim both the proceeds and the partnership share. In fact, in one such case⁴⁵ the agreement was held to be unclear, and the widow was allowed to keep both the proceeds of the policy and the partnership share.⁴⁶ When the insured's beneficiary is named, the partnership interest is in the estate, but the purchase price for it goes directly to that beneficiary. Creditors with claims against the estate may object to the transfer of estate assets (the partnership interest) without any direct compensation of the estate. A number of companies make it possible for the heirs of the deceased to use the settlement options under the policy, even though the policy is made payable to the surviving partner or the partnership. Various plans are available, for example, the "additional direct beneficiary" arrangement. Under this plan, after the terms of the buy-and-sell agreement have been executed, the direct beneficiary releases the policy proceeds for the "additional direct beneficiary" (the insured's beneficiary) who can take them under the settlement options.

Personal Service Partnerships. The personal service partnership (such as a firm of lawyers, investment bankers, a medical partnership, and the like) often will use an income-continuation agreement instead of a lump sum payment. Under this plan it is provided that for a specified number of years after the death of a partner, the firm will share a percentage of its profits with the heirs of the deceased. Sometimes there will be two agreements: one a regular buy-and-sell agreement covering tangible assets including receivables, and the other an income-continuation agreement covering the deceased's share in future earnings. Life insurance can be used to fund both agreements.

⁴⁵ *Price v. McFee*, 196 Maryland 443, 77 A (2nd) 11

⁴⁶ There is also a tax danger for the survivor or survivors. In *Legallet v. Commissioner*, 41 B.T.A. 294, the amount of the insurance proceeds paid direct to the widow of the deceased partner by the policy was not allowed as part of the cost basis of the partnership share of the survivor when he subsequently sold the firm assets. As a result, he was forced to pay a higher capital gains tax than would have been necessary had he or the firm received the proceeds and paid them over to the widow.

4. CLOSE CORPORATION INSURANCE.

In many corporations, the stock is owned by a limited number of people, most if not all of whom also are active in the business, usually as officers or executives. This type of organization is called, a "close corporation."

The close corporation has an existence apart from the individual stockholders.⁴⁷ However, the relationship among the stockholders is almost exactly the same as that among partners. In fact, the relationship is so intimate and personal that the close corporation is often called an "incorporated partnership." Unlike the partnership, however, the withdrawal or death of a stockholder has no legal effect on the continuation of the business, although it will necessitate a realignment of ownership which can create problems—unless proper plans are made to take care of the contingency.

The relationship among stockholders in the close corporation is so close that it breeds the same feeling of moral responsibility for one another as is often found in partnerships.⁴⁸ Further, the close corporation is closed because the existing stockholders do not want to admit new stockholders—at least stockholders they cannot select for themselves.

Out of the close relationship of close corporation stockholders grows the need for close corporation insurance.

If a Stockholder Becomes Disabled. The effect of the disability of a close corporation stockholder who is also an employee of the firm is almost identical with that resulting from the disability of a partner. He will continue to share in the profits of the company although contributing nothing to them. A replacement for him will have to be hired, costing additional money. Probably the company will feel an obligation to continue his salary over a long period of time. If the stockholder is a key man, as is often the case, the firm may suffer a loss of income as well as incur additional expenses. Partnership disability income insurance can be used in the close corporation to offset these extra expenses and the loss of profits in exactly the same way as it can be used in the key man situation or the partnership.

When a Stockholder Dies. When a close corporation stockholder dies, there is no legal effect on the company. His shares simply become a part of his estate, eventually passing on to the heirs. Here, however, is the situation in which trouble lies.

⁴⁷ Under the 1954 Revenue Act, for some purposes, at least, a partnership can be dealt with as an "entity" apart from individual owners; thus the "entity" plan referred to previously. The tax code says, "If a partner engages in a transaction with a partnership other than in his capacity as a member of such partnership, the transaction shall be considered as occurring between the partnership and one who is not a partner." I.R.C., Section 707 (A).

⁴⁸ This is not to say that all partners and close corporation stockholders feel a moral responsibility for the welfare of one another. Examples of partners and close corporation stockholders who live in absolute hatred of one another could be found. The point is that partners or close corporation stockholders usually become associated because they know and have an interest in one another. This close relationship usually is conducive to the development of a feeling of obligation for one another's welfare.

While a partner cannot be forced to take in a partner against his will, a close corporation can be forced to take in as a stockholder the heir of a deceased stockholder or the person to whom the heir has sold his inherited stock. Anyone who holds legal title to stock becomes a part of the company regardless of what may be the wishes of the surviving stockholders. The new "member" might even be a competitor. The surviving stockholders could do nothing to keep him out or to bar him from full information about the operations of the firm.

Such is the major problem created for the surviving stockholders at the death of a close corporation stockholder.

The heirs of the deceased minority stockholder are faced with problems, too. Stock in a close corporation in which one is not actively engaged, usually is considered a speculative investment at best. Since close corporations are normally highly dependent on the skills and abilities of a limited number of stockholder-executives, the degree of safety of principal is usually low. Earnings on such stock are unpredictable for the same reason. Further, dividend earnings may be low because employee-stockholders are frequently more interested in ploughing profits back into the business rather than declaring dividends on the stock; and they may vote themselves salary increases and bonuses which take up a large part of the profits available for dividend distribution. The "old" stockholders with the controlling interests could freeze the "new," unwanted stockholder out of the business. It is true that minority stockholders have enforceable rights and can sue to force distribution of surplus or profits as dividends and to stop unreasonable salary and bonus payments; but any investment under which the owner must argue with others about return and resort to costly law suits is hardly the kind of investment to leave to an heir.

If the estate or heir wishes to sell stock in a close corporation, he has difficulty in finding a buyer, and, if lucky enough to find a buyer, has even more trouble establishing a price. The very factors that keep close corporation stock from being a good investment for heirs also prevent it from being a good investment for anyone who does not intend to work actively for the company or whom the firm would not accept as an employee even if he were willing. Since future earnings on the stock are unpredictable, and since there is no market price for the stock, its value is not clear. The seller is prone to value it high. The buyer is prone to value it low because of its inherent drawbacks. The gap between the two valuations is often too great for successful negotiation.

The heirs of a majority stockholder are also faced with problems. While it is true that by their control they can set whatever business or financial policies they wish and, in effect, say to the minority stockholders, "Do as we say or get out," the nature of the close corporation is such that often heirs of a majority interest cannot get along without the co-operation of the minority. As has been brought out, many if not all of the minority stockholders in the

usual close corporation are also key employees in the firm. The heirs are often not acquainted with the business or not enough interested in it to risk losing the key men. Also, since the minority stockholders are active employees, they are in a position to sabotage the heirs, should they wish.

If the minority stockholders are left to run the business while the majority heirs act as "silent partners," the minority can conduct the business so that dividends to the heirs become negligible. For instance, they can put profits back into the business, living on their salaries. Further, as minority stockholders, the survivors could exercise rights that could cause the majority heirs embarrassment and trouble.

Finally, if heirs inheriting a majority interest wish to sell, the minority interests may not have the money to buy at a price that will give the heirs anything like their proportionate share of the going business. The problems of finding an outside buyer have been discussed.

One more problem faces the heirs of a deceased stockholder: valuation of the stock for tax purposes. Since there is no yardstick in the form of an established market price (and rarely a value established by a prior sale close enough in time to have any bearing), there can be a wide discrepancy between the value set on the stock for federal estate tax purposes by the executor and the value set by the government. Trust officers report that the valuation problem of stock in close corporations, for estate tax purposes, represents one of the greatest difficulties in estate administration and often results in excessive administration costs. On the other hand, if the buy-and-sell agreement and the method of valuation used in it have been negotiated at arms' length and in good faith, the government will consider the valuation of the stock under the agreement as acceptable for tax purposes.⁴⁹

Thus, from the standpoint of both the surviving stockholders and the heirs, the best arrangement in the vast majority of cases will be for the survivors to buy, and the heirs to sell, the stock of a deceased stockholder. Again, in view of the problems encountered when an attempt is made to negotiate the sale after the death of the stockholder, which problems are the same as those in the case of the partnership, the best way to handle the sale is through a buy-and-sell agreement among the stockholders, put into effect while they are all alive. Such agreement is, of course, of little value unless there is also money to pay for the stock. The agreement can be funded in various ways but, as in the case of the partnership buy-and-sell agreement, life insurance offers the best method in the vast majority of cases.⁵⁰

How the Insurance Is Arranged. The two most common types of purchase agreements are the *individual* and the *stock retirement* plans.

⁴⁹ *May v. McGowan*, 194 F. (2nd) 396. (Numerous other cases could be cited.)

⁵⁰ If one of the partners or stockholders is uninsurable, other funding methods will have to be used with him. Life insurance can continue to be used with the insurable partners or stockholders.

Under the individual plan, each stockholder agrees to buy a portion of the stock of the deceased stockholder. Each purchases, owns, and maintains the insurance necessary to fund his purchase. The plan is exactly the same as the partnership cross-purchase arrangement and is, indeed, often known by that name. The advantages of the plan when used in connection with the close corporation are the same as those available when the plan is used with the partnership.

Under the stock retirement plan, the corporation agrees to purchase the stock of the deceased shareholder and purchases, maintains, and owns the insurance necessary to fund the agreement.⁵¹ This plan is the counterpart of the partnership entity plan. The advantages and disadvantages of the stock retirement plan are the same as those of the entity purchase plan, except for the tax question. However, since corporations are not authorized in every state to buy their own stock, it will not always be usable.

In the partnership plans it makes no difference, taxwise, who pays the premium—the partners or the partnership. Since the partnership is not a separate tax entity, whatever the partnership earns is taxable as income to the partners. Premiums paid by the partnership are not deductible as an expense, and therefore are considered as part of the partnership income taxable to the partners. In the corporation plans, it makes a tax difference who pays the premium. Premiums paid by the corporation are not deductible by the corporation; but since a corporation is a separate tax entity, they are not reportable as income to the stockholder. Earnings of a corporation are taxable to the stockholder only when they are paid out as dividends. Therefore, the choice of plans can have a real effect on the tax burden. For example, the corporation can pay the premium directly or increase the salaries of the stockholders to allow them to pay the premiums.⁵² The tax question can be important in the decision because the premiums on the insurance are a nondeductible expense for the corporation, whereas salaries are deductible for the corporation but reportable as income to the stockholder. Thus, which plan will cost less in income taxes depends on a comparison between the marginal tax rate being paid by the corporation and the marginal tax rates being paid by the individuals. If the corporation is

⁵¹ Where the stockholder is also an employee, the agreement often calls for him to sell and the corporation or stockholders to buy his stock in the event he severs employment. The price for his stock is set in the agreement, either at an actual figure or through the establishment of a formula. Cash values in the insurance carried on his life can be used to fund the purchase. However, since cash values may be insufficient at the time he leaves employment, and since it might be financially impossible for the corporation or the individual stockholders to meet the agreed price, provision may be made to pay the balance in installments or to allow the stockholder to dispose of the stock himself if the buyers are unable to meet the established price or make a satisfactory settlement.

⁵² Or reduce the salaries of the stockholders and pay the premiums itself, as the case may be.

paying more than the individual shareholders, the individual stock repurchase plan will cost less in taxes. If the stockholder is paying more than the corporation, then the stock retirement plan will cost less.

If the close corporation stockholder is also an employee, it may be desirable to provide, in the buy-and-sell agreement, for the sale of his shares in the event of permanent disability as in the case of the partnership agreement or their conversion to a non-voting issue. If he is not an employee, there would be no reason for this provision.

The trustee plan can be used in connection with the close corporation the same as with the partnership agreements and insurance.

Who Shall Be the Beneficiary? Problems of beneficiary designation under close corporation insurance are the same as those under partnership insurance. If the cross-purchase plan is used, the stockholders themselves can be made beneficiaries of the insurance they carry on each other. If the stock retirement plan is used, the corporation can be the beneficiary. The value of a trustee as beneficiary in the close corporation case is the same as in the partnership case. The problems and disadvantages of naming the heirs direct beneficiaries or naming the estate of the insured are the same as in the partnership case.

5. MISCELLANEOUS USES OF BUSINESS INSURANCE.

In addition to the business uses of life and disability insurance that have been discussed, several others might also be classified under the heading of "business insurance."

Collateral Uses. Many of these miscellaneous uses are actually collateral advantages of the uses of disability and, especially, life insurance for key man protection, business interest liquidation, and business continuation. They serve as predeath or predisability advantages of the insurance which is purchased for postdeath and disability uses. These uses are:

(1) Key man insurance aids in establishing credit for a business. Creditors and lenders frequently are more aware of the importance of key personnel to the financial standing of the business than is business management itself. Many a bank loan has been made or line of credit extended, not so much because of the financial aspects and physical characteristics of the business, but because John Doe is president, or general manager, or in some other key position. Creditors recognize the added strength that key man life insurance gives to a firm.

The value of key man disability insurance is far less understood by creditors and lenders, largely because so little key man disability insurance is in force. Yet the effects are the same whether a man's services are lost to the business because of death or because of disability. Inevitably, as the use of business disability insurance spreads,⁵³ its value in strengthening credit will increase.

⁵³ Such spread is itself inevitable as sales activity in the health insurance field grows.

(2) Business life insurance makes cash and loan values available to the business. Life insurance policies other than term are good collateral for loans. The life insurance company is contractually bound to make such loans up to the cash value of the policy at a contractually set rate of interest regardless of the money market at any given time. Banks and other lending agencies always will accept life insurance policies as collateral for loans. If money is easy, they will usually lend at a lower rate of interest than that set in the policy.

Policy loans made by the insurance company have another value: They can be made confidentially. Occasions arise when a business firm may not want it known in banking or credit circles that a loan was needed. A policy loan can be effected without the knowledge of such circles.

(3) Business insurance also can be used as an aid to corporate financing. Where the success of a business enterprise is recognized to be largely dependent on one man, or where a stock is being issued to finance a program of development the success of which will be largely in the hands of one man, it is possible to use key man insurance to back the issue and thus add a margin of safety that will make the issue more attractive to investors. In event of the key man's early death, proceeds from the policy can be used to retire the stock.⁵⁴ It might be possible also to take an endowment policy on the life of a key man, using the proceeds for the retirement of a block of, say, preferred shares.

(4) Key man life insurance permits accumulations that are less liable to criticism from stockholders. This is especially important where there are minority stockholders not actively engaged in the business. To them, the accumulation of reserves may seem a means of depriving them of dividends. Minority stockholders have distinct rights in law. They have been known to cause business embarrassment and expense by threatening or bringing suit against officers for alleged attempt to accumulate reserves to avoid payment of dividends.⁵⁵ Such stockholders are less likely, however, to look upon the

The uses of insurance expand as competition becomes keener and agents reach out for new markets. The present state of development of business disability insurance is roughly comparable to the status of the use of business life insurance about thirty years ago.

⁵⁴ It appears from a study of court decisions in such cases (cf. *Ellsworth v. Lyons*, U.S. Circuit Court of Appeals, 6th dist., 181 Fed. 55 and *Tweedie Footwear Corp. v. Fonville*, Texas Court of Civil Appeals, 115 S.W. [2nd] 421), that the proceeds would have to be payable to a trustee for the specific benefit of the holders of the block of stock rather than to the corporation.

⁵⁵ There is also the possibility that accumulation of cash funds to redeem stock of shareholders will be subject to the imposition of an accumulated earnings tax. Edwin M. Jones, counsel for New York Life, speaking before the insurance section meeting of the New York State Bar Association, was quoted by *The National Underwriter* (Chicago, March 12, 1960) as stating, "In two cases where substantial sums were accumulated and used to redeem stock of shareholders, the penalty tax was imposed. In neither case was insurance purchased. It may be that these cases indicate that the way to avoid the accumulated earnings tax is to buy life insurance since the use of insurance requires less

cash values in key man insurance as an unreasonable surplus accumulation. Life insurance as a means of accumulating liquid reserve funds has the same advantages for the business as it has for the individual, among them regularity of saving, automatic management of funds, safety of principal, high convertibility, automatic compounding of interest, tax-free interest increments during accumulation, and the like.

Other Primary Uses. A number of other uses of business insurance are available, which are primary rather than collateral uses. These are:

(1) *Credit Insurance.* Life insurance is widely used as security for credit or loans. The creditor or lender may require the borrower to assign existing life insurance as collateral; or the lender may himself purchase and maintain life and disability insurance on the borrower. Credit insurance is widely used to guarantee installment purchases, usually in the form of group insurance, as discussed in Chapter 13.

(2) *Group Insurance.* Group life and disability insurance is an important use of life insurance in business. Group insurance is discussed in Chapter 13.

(3) *Insurance in Pension Plans.* The use of life insurance and annuities in pension and profit-sharing plans is discussed in Chapter 14. This is becoming a more and more important use of life insurance in business.

6. TAXES AND BUSINESS LIFE INSURANCE PLANNING— A SUMMARY

Life insurance tax planning, while a major consideration in any type of life underwriting, is especially important in the field of business insurance. It is here that many pitfalls, unknown to the uninformed, can be avoided and that substantial reduction of income and estate tax liability can be accomplished.

Life insurance may be purchased to fund agreements among partners or co-stockholders. Jones and Smith are partners. They come to an agreement between themselves and their wives that when one of the partners dies, the survivor will buy the partnership interest from the wife of the deceased. The deceased's wife agrees to sell at a price determined in advance.

To assure that the funds required are available and to obtain those funds at the lowest possible cost, life insurance is purchased. Jones buys a \$30,000 policy on Smith's life, and Smith buys the same amount on Jones's life. When Jones dies, Smith has enough money from the proceeds of his insurance on Jones's life to provide him with the means of buying Jones's partnership interest from Jones's wife.

In the absence of a trust agreement, most insurance authorities consider

cash to be accumulated. In any event, there are cases supporting the view that the purchase of insurance has a reasonable business purpose when such insurance is designed to provide for continuity of management. My personal view is that this proposition will one day be firmly established in the law."

that the best arrangement is for Jones to be the beneficiary on Smith's policy and for Smith to be the beneficiary on Jones's policy. Frequently, however, each man will make his wife the beneficiary of the policies on his life. This can be expensive in taxes.

For example: Jones and Smith each have a \$30,000 original interest in the firm, so each buys a \$30,000 policy on the other's life. Jones's wife is beneficiary of the policy on his life, and Smith's wife is the beneficiary of the policy on Smith's life. Jones dies, and his wife gets the \$30,000 proceeds from the insurance company. She has signed an agreement to deliver Jones's interest in the partnership to Smith, and she delivers it.

Smith now owns a \$60,000 business in which he originally invested \$30,000. If he had been the beneficiary on Jones's policy, he would have received the proceeds from the insurance company and turned over the \$30,000 to Jones's wife in exchange for the partnership interest.

However, since Jones's wife received the \$30,000 direct from the insurance company, Smith still has only his original \$30,000 invested in a business now worth \$60,000 to him. If he later sells the business he will have to pay income tax on the difference between his original \$30,000 investment and whatever price he receives for the business. On the other hand, if he had been Jones's beneficiary, he would then have had a \$60,000 investment in the business, and his cost basis for tax purposes would be \$60,000, not \$30,000.

The same principle would apply on an agreement to buy out co-stockholders in a corporation.

Circumstances alter cases, and in many instances it is advisable for the corporation to be the beneficiary under an entity plan; but it is important to consider whether the surviving stockholders would not fare better under a cross-insurance plan with each stockholder paying the premiums on the lives of the others and with the surviving stockholders named as beneficiaries.

Brown, Jones, and Smith are the sole stockholders of a small corporation. Each owns 100 shares. They enter into a cross-purchase agreement under which each insures the others. Brown dies, and as beneficiaries on Brown's life, Jones and Smith each receive \$1,000 from the insurance company, which they use to buy Brown's stock from his widow.

Jones and Smith now own 150 shares each. Their cost basis for those 150 shares owned by each is the original cost of their 100 shares plus the \$1,000 they received from the life insurance company and which they used to buy Brown's stock. When, as, and if Jones or Smith sells his stock, his income tax liability will be on the difference between his original investment including the \$1,000 life insurance proceeds and the selling price of the stock.

On the other hand, if the corporation were the beneficiary and used the insurance proceeds to buy the stock from Brown's widow, subsequently retiring the stock from the corporate treasury, Jones and Smith would then own all the stock in a corporation whose book value had increased because

of the retirement of Brown's stock, but both Jones and Smith would still have as their cost basis, only their original investment in their respective stock interests.

It will be recalled, however, that there might be an income tax advantage for the corporation to pay the premiums under the entity plan. The corporation can pay the premiums without such premiums being taxable as dividends to the stockholders or as salaries to employee-stockholders. If the money were paid out first to the stockholders and used by them to buy the insurance under a cross-insurance plan, the money would be taxable income to the stockholders and unless considered salaries would not be deductible by the corporation.

Deductibility of Premiums. Life insurance premiums are not deductible when paid on the lives of partners or sole proprietors. Premiums are deductible as a business expense when paid by corporations only when the corporation is not the beneficiary and holds no incidents of ownership. If, for instance, the Consolidated Corporation pays the premiums on the life of an officer or other employee and that employee's wife is the beneficiary, the premiums are deductible by the corporation provided, of course, that the corporation has no incidents of ownership. The amount of the premiums, however, constitutes additional taxable income to the employee whether he be an officer or a general employee. Group insurance, as will be seen, is an exception to this rule.

It is important to bear in mind that the life insurance premiums, when added to other compensation such as salaries and bonuses, must be reasonable. The total must not be so out of line that the Internal Revenue Service will consider it excessive compensation for the amount and type of services rendered by the stockholder or officer.

The premiums, moreover, must be clearly shown to constitute compensation to the employee. In one case a stockholder-employee who was a corporate officer was paid a salary and, in addition, under an agreement among the stockholders, the corporation paid the premiums on his insurance. The court held that the premium payments were not additional compensation but were dividends and therefore not deductible as business expense.

The situation with respect to health insurance premiums is slightly different. The reasonableness of health insurance premiums is determined independently of the total compensation paid to the insured. The employer can deduct reasonable premiums paid to maintain health insurance on the employee for the employee's benefit.⁵⁶ In a recent case⁵⁷ the Tax Court held that premiums on health insurance for the benefit of certain corporate executives were deductible, even though a substantial part of their salaries was disallowed as exceeding reasonable compensation. On this matter the court said: "It is not

⁵⁶ Remember, unlike life insurance premiums, these premiums do not constitute taxable income to the employee (I.R.S., Section 106).

⁵⁷ *Ernest, Holdeman, and Collet, Inc.*, 19 T C M. 40, (1960).

unusual for a corporation to provide such insurance. The amounts paid were neither unreasonable nor excessive . . . the payments cannot, therefore, be regarded as dividends."

Section 303 of the Internal Revenue Code. If a corporation buys a part of its stock from a stockholder, the price paid to the stockholder usually will be treated as taxable distribution. This is the rule under Sections 301 and 302 of the I.R.C. But under Section 303, where stock is included in the gross estate of the decedent, a redemption of such stock by the corporation for an amount equal to the sum of death taxes, funeral, and administrative expense will not be considered a taxable distribution if the value of the stock is more than 35 per cent of the value of the gross estate or 50 per cent of the value of the taxable estate.⁵⁸ Life insurance on the principal stockholder, purchased and owned by the corporation, can provide the funds necessary to purchase the stock from his estate. The use of this plan enables the surviving stockholders to hold on to this business interest and thus help perpetuate the control of a family corporation.

Income Taxation of Group Insurance. Payments of premiums by an employer for group life insurance are a deductible business expense and do not constitute taxable income to employees. There are, however, certain restrictions and rules that must be applied. The employee must not name the employer as beneficiary, and there must be no blanket or individual assignment of the policies to the employer. Group insurance premiums on the lives of employees are deductible business expenses not only for corporations but also for partnership employers or employers who are sole proprietors.

The Technical Amendments Act of 1958. A new subchapter to Chapter 1 of the Internal Revenue Code was added in 1958. This addition, known as Subchapter S, makes it possible for an unincorporated business to incorporate while retaining the tax status of a partnership if the corporation meets certain conditions.⁵⁹ These corporations, sometimes referred to as Subchapter S corporations, are treated as regular corporations for all except tax purposes.

The significance of this Act to the field of business insurance is that fringe benefits unavailable to business owners under the partnership or pro-

⁵⁸ If stock of two or more corporations is included in the gross estate, the combined stock may be treated as the stock of a single corporation for the purposes of applying the 35 per cent or 50 per cent tests provided that the gross estate includes more than 75 per cent of the outstanding stock of each corporation.

⁵⁹ The conditions are that there must not be more than ten stockholders; all stockholders must consent to the election to be taxed as a partnership; there can be only one class of stock; the stockholders must be individuals or estates, the corporation must not be an alien corporation; the corporation must not own 80 per cent or more of a subsidiary corporation; more than 80 per cent of the corporation's gross receipts must not be derived from foreign sources; and more than 20 per cent of the corporation's gross receipts must not be derived from certain sources of personal holding company income: rents, royalties, dividends, interest, annuities, and security transactions.

prietorship form of business organization can be made available to the stockholders of Subchapter S corporations. Since partners and proprietors are employers rather than employees, they are not eligible to participate in qualified pension and deferred profit-sharing plans. But in a Subchapter S corporation the stockholders who work for the corporation are employees along with the other working force, and are therefore entitled to be included in a qualified pension or deferred profit-sharing plan and enjoy its tax advantages.

Available to a Subchapter S corporation but unavailable to owners in a partnership or sole proprietorship is the \$5,000 tax-free death benefit which can be paid to the stockholder-employee's widow upon his death. Also, the corporation can purchase health insurance on the stockholder-executive without the premiums being taxable income to the employee. A partnership or proprietorship cannot purchase health insurance on its owners with tax-free dollars.

The Technical Amendments Act of 1958 included among its 103 sections, other provisions affecting business life insurance. An important one deals with the income tax treatment of nonforfeitable annuity contracts purchased by tax-exempt educational, charitable, or religious organizations. The law was amended to provide that premiums paid by such organizations for employee nonforfeitable annuities that are not a part of a qualified pension plan are to be taxed to these employees only to the extent that they exceed a given exclusion determined by applying a formula set up in the act.

7. SUMMARY.

In addition to group, pension, and profit-sharing uses of insurance in business, there are other situations in which life and disability insurance can be of value in guarding against business loss and disruption resulting from the disability or death of an employee or part-owner.

(1) Insurance can protect the business against the loss and extra cost that come when a key man is disabled or dies. It can also be used to attract and retain key men.

(2) It can protect the heirs of the sole proprietor against (a) the loss in value in his business resulting from his death or disability and (b) against the possibility that business obligations will siphon off other estate assets.

(3) It can protect the partnership against the drain that the disability of a partner will cause and assure continuation of the business in event of the death of one of the partners. It can also protect the heirs of the deceased from the loss that will come if the business cannot be continued and must be liquidated.

(4) It will protect the close corporation from the loss that disability of a stockholder-employee can occasion and against the entrance of unwanted interests into the business in event of the death of a stockholder. It also guarantees the heirs of the deceased a market for their shares at a fair price; and it sets the valuation of their shares for estate tax purposes.

In addition, life insurance has several miscellaneous uses in business: as credit, as backing for corporate financing, as a method of building reserves and for compensation plans designed to hold valued employees.

QUESTIONS FOR CLASS DISCUSSION

1. Do you see any inconsistency in the taxation of key man insurance and the taxation of fire insurance purchased for a business? Discuss.
2. Alec Trician, the sole owner of a large electrical supply house, was shocked to hear of the untimely death of his best friend. When he learned of the shrinkage of his friend's estate, he immediately generated some interest in the problem of estate planning. Alec decided to conduct a study of his own problem and charged you with the responsibility of enlightening him on the avenues of approach to a solution. Since Alec's estate included little more than his business, the problem was simply one of preserving the value of this business interest. Alec, 39 years old, has a wife and two children, a son aged 18 and a daughter aged 16. Assume that Alec's son has his heart set on eventually taking over the business and is studying electrical engineering and business management at the university, and that Alec's daughter is madly in love with a mediocre piano player, and it looks like the real thing. Alec's wife is a good mother without any business sense. With this set of facts, it becomes obvious that Alec would want his estate to hold on to the business interest in the event of his death. What plans, if any, should Alec make to protect his business after his death until his son is ready to take over? Would life insurance be helpful in these plans? Discuss.
3. What other problems should Alec consider in his estate plans if he should decide to will the business interest to his son? Would life insurance be helpful in handling any of these problems? Discuss.
4. A business might have uses for life insurance which are totally unrelated to the estate planning objectives of its owners. They are uses which are in no way connected with the life or death of the owners in their functions as owners. Discuss the ways in which life insurance can be used effectively by a business in improving employee relations.
5. Aside from the use of business life insurance in estate planning and employee relations, what other legitimate needs might a business have for life insurance?
6. Good business management principles dictate the use by most partnerships and close corporations of buy-and-sell agreements funded by life insurance. Any other arrangement except in unusual circumstances appears to be pure folly. It is important, therefore, that both the philosophical and the technical aspects of buy-and-sell agreements financed by life insurance be understood by those who use them or advise their use. As to the philosophical aspects—
 - (a) Explain briefly why properly financed buy-and-sell agreements are so important to the surviving partners or stockholders, and
 - (b) Explain briefly why life insurance is the ideal financial instrument for use in funding these buy-and-sell agreements.
7. As to the technical aspects in arranging insurance to fund a partnership or close corporation buy-and-sell agreement, several decisions need to be made.

For example, questions relating to policy *ownership*, policy *beneficiaries*, and *premium payments* have to be settled.

- (a) Outline what you consider to be the best answer to each of the above questions for the rank-and-file business insurance case and give the reasons for your choice.
 - (b) Indicate what factors or characteristics of a given partnership or close corporation case would lead you to recommend some answer other than the ones indicated above and point out (with reasons) what your new answers would be.
8. A & B have entered into a partnership buy-and-sell agreement. The insurance was arranged so that A's wife would be the beneficiary on the policy on A's life and B's wife would be the beneficiary on the policy on B's life. Each has signed an agreement to deliver her husband's interest in the partnership to the surviving partner. Assume the partnership is worth \$50,000—each partner owning a \$25,000 interest and each partner being insured for that amount. A dies and his widow receives \$25,000 from his policy and then turns over A's interest in the partnership to B as agreed. Can you see any *possible* income tax disadvantage in this arrangement to B if B subsequently sells the business? If so, what plan could have eliminated this disadvantage?
 9. In the above case, would the \$25,000 life insurance proceeds paid to A's widow upon A's death be subject to the federal estate tax on A's estate?
 10. A, B, and C are the stockholders of a close corporation, and own 100 shares of stock each. The corporation purchases \$20,000 of life insurance on each stockholder (the value of each stockholder's share) and names itself as beneficiary. It enters into an agreement to purchase the shares of a deceased stockholder. A dies and the corporation purchases A's stock from his widow with the proceeds of the \$20,000 life insurance policy. Can you see any income tax disadvantage of this arrangement to C if he should later sell his stock for \$40,000? What plan could have eliminated this disadvantage? Can you see any income tax advantage in having the corporation purchase the life insurance? If so, what?
 11. Explain how health insurance can be used in estate planning where there is a business interest. How can health insurance be used in employee relations?

CHAPTER 19

Underwriting the Risk

Mortality tables are employed in the calculation of life insurance rates. The tables used are a compilation of mortality experience among insured lives. Therefore, when new persons are added to the insured group, they must be of the same average health as the lives upon which the tables are based if future experience is to approximate the past experience shown in the tables.

The process used to determine average health (and the other factors involved, such as habits and occupation) is known as "underwriting the risk" or "selecting and classifying the risk." The former is probably the better term. The latter might imply that the process is one of choosing only the best risks, which is not the case. Instead, the process is more that of making sure that no one is accepted who is an excessive risk, based on the company's standards of selection. It therefore becomes necessary to reject some applications and to charge others an additional premium to make up for poorer health, occupational dangers, or the like.

Industry figures show that out of every 100 regular ordinary life insurance policies applied for, three are rejected.¹ Five of every 100 ordinary policies issued and paid for require an extra premium.² Currently, about 6 per cent of all ordinary life insurance in force is extra premium insurance.

Ideally, companies would like to be able to offer some type of coverage to everyone who applies, because rejections cause adverse public relations and often are both irritating and discouraging to agents.

Sometimes the applicant has just been examined by his own physician and told he has "absolutely nothing to worry about." Too often the medical examiner, despite instructions, reminders, and cajolery from the company, pats the applicant on the back, and remarks, "You passed with flying colors."

The family physician who is treating an individual patient does not

¹ This is not a picture of the insurability of the American public at large, but only of people who apply for ordinary life policies. Among those who don't apply, and therefore do not appear in this summary, are (1) those who know they would not be accepted, and hence never apply in the first place, and (2) those whom the agents know would not be accepted and whom they therefore never solicit.

² Heart conditions are the principal cause of extra rates, followed by overweight and underweight. Physical conditions account for 68 per cent of the extra rate policies, hazardous occupations account for 26 per cent, and all other causes account for the remaining 6 per cent.

have statistical evidence to support his prognosis. He may feel it is better not to frighten the patient about a condition, or he may consider whatever condition exists to be compensated. The home office medical director and underwriting department, however, are dealing with a mass of risks. They know that a given impairment about which the family physician is not concerned in the individual case will produce a greater mortality in the mass.

In the case of the physician making the examination, his function is not to "pass" any applicant. His function is only to report his findings to the company. Almost never is he even qualified to form a judgment. Insurance medicine is a technical branch of the profession in which few practicing physicians are qualified.

The whole situation can be aggravated by the fact that when a company rejects the three applicants out of 100, it is not always able to tell the applicant or agent the reason, since it may be confidential. The result can be an ex-applicant who publicly criticizes the company and an irritated agent who spends time he should be using to solicit or service business to engage in protracted correspondence with the company about the case³

This chapter will describe the various classifications of acceptable applicants and the relationship of the information from various sources to the standards against which applicants are measured. It will also deal with the nature and expense of non-medical life insurance and touch upon the importance of reinsurance.

³ The author of the following poem (sung to the tune of "Oh, My Darling Clementine") is unknown, but in a humorous and exaggerated manner it clearly depicts the gist of a lot of correspondence in the files of the Medical Departments of many life insurance companies.

"My Dear Agent," wrote the Doctor,
 "Application of Jim Brown
 Is declined for valid reasons;
 Sorry, but we've turned him down."
 "My Dear Doctor," wrote the Agent,
 "Your form letter just received,
 And the information given
 Makes me just a little peeved.
 In the first place, my dear Doctor
 I have known this man a year,
 And I've never seen him drinking
 Much of anything but beer.
 He don't chew nor smoke tobacco,
 He don't toddle to the Jazz;
 I can't detail all the virtues
 That this super-standard has"
 "My Dear Agent," wrote the Doctor,
 "You are certainly some kiddier
 Case-of-Jim-Brown still is turned down,
 Sorry; cannot reconsider."
 "My Dear Doctor," wrote the Agent,
 "Your decision makes me sigh—
 Brown's entitled to a contract;
 If he isn't—*tell me why.*"

"My Dear Agent," wrote the Doctor,
 "Brown's case shows much albumin,
 Mitral murmur, high blood pressure,
 And the fat man's prize he'd win"
 "My Dear Doctor," wrote the Agent,
 "Brown has trivial ills, that's true,
 But they're family characteristics;
 So it's safe to pass him through.
 Why, his father had a murmur
 You could hear a block or more;
 His old grand-dad had albumin,
 And he lived to ninety-four.
 Note the weight's good distribution;
 Pressure shows the heart is strong.
 He has never had a hemorrhage;
 So please rush the contract on."
 "My Dear Agent," wrote the Doctor,
 "Application of Jim Brown
 Is declined for valid reasons;
 Sorry, but we've turned him down."
 When the Agent got this letter
 He just settled back and sighed,
 For he couldn't argue further,
 'Cause his "prospect" had just died.

1. THE NECESSITY FOR SELECTION.

Adverse Selection. In any voluntary insurance program, there always will be selection. An insurance company has the choice of selecting or being selected against.

If one knew he were going to die or become disabled tomorrow, he would beg or borrow the largest sum of money he could get to buy insurance tonight. But as long as death or disability is not imminent, the typical person thinks next week, next month, next year will be soon enough for him to insure. When the public is left to its own initiative to buy insurance, among those who apply for it will be the poorer risks. As a result, mortality or morbidity among a group that includes unsolicited and unselected applicants will be greater than that anticipated among solicited and selected applicants. The company must therefore reject or rate up all applicants whom it can recognize as not measuring up to its standards. Were a company not to apply rigid selection standards, applicants who might be rated or rejected by other companies would gravitate to that company. This would be an example of selection against the company and is known as "adverse selection." Adverse selection could well lead a company to eventual financial difficulties.

Inequity of Cost. It would be possible to compile a mortality or morbidity table in which the rate per thousand would be, within practical limits, the same as the rate among unselected and unsolicited applicants. However, since this group of unselected applicants would contain a number of poor risks, the mortality or morbidity rate would be higher. If such a table were used in rate computation, it would lead to a higher premium.

It is theoretically true that any rate is inequitable for every applicant except the average one. Since the average is a statistic rather than a human being, it becomes technically correct to state that any rate is inequitable for *all* applicants. But the operation of the insurance principle depends upon large numbers. If there are too many classifications, there will not be a large enough group of people in any one of them to assure the same operation of the law of large numbers. The companies must make their classifications sufficiently broad to produce stability of experience. Hence, while there are technical inequities in any practical rate, there is a limit to the extent to which they can be eliminated. The purpose of risk selection is to determine not only who is insurable but also what degree of insurability he possesses.⁴

⁴ The degree of rate inequity for a given policyholder increases with the extent that he is above or below the *average* of the classification in which the underwriting standards place him. Very good risks, for example, pay proportionately more than is really necessary to uphold their share of the burden. In recognition of this fact, there has been a tendency among companies to segregate such risks by offering at lower rates a "special" or "select risk" policy, underwriting standards for which are higher than for other policies. This helps adjust the inequity for the "superstandard" risk but increases it for the average risk since, with the superstandard risks skimmed off the top of the group, mortality experience for the group now becomes poorer, and the mortality cost for the group now goes up. In effect, when the superstandard risk is taken off the top of the group,

2. BASES OF SELECTION.

Several different selection factors are used by underwriting departments of life and health companies. Among them are. (1) age, (2) sex, (3) plan of insurance, (4) occupation, (5) residence, (6) race and nationality, (7) family and personal history, (8) physical condition and physique, and (9) financial condition. Some discussion of the nature and importance of each of these bases will be helpful in understanding both the questions asked on a life insurance policy application and the reasons why some applications are rejected.

Age. Every company establishes maximum ages above which it will not issue policies. The maximum for new life insurance usually is 65.⁵ An increasing number of companies write new insurance as late as age 70, and a few even will write new insurance at age 75. An exception usually is made for term insurance where the maximum age commonly is set at 60.

Several explanations may be given for establishing maximum age limits. As a practical matter, the number of applications for life insurance which could be obtained above age 65 would be insufficient in the typical company to constitute a group large enough for the safe operation of the law of large numbers. At age 65 the need for new life insurance is frequently nonexistent, the cost almost prohibitive, and the possibility of passing the physical examination remote. A danger in issuing policies to applicants over age 65 is the possibility that the purchaser may be buying the policy as a speculation. Companies find it good underwriting practice to decline insurance when no real need exists.

Some companies, however, recognize that at times there may be a need for new life insurance beyond the published maximum age limit. To meet this demand, they have a special set of rates for applicants up to, perhaps, ten years above the regular limit. These rates are confined to but one or two plans of insurance (usually continuous-premium whole life) and are adjusted to take care of the problem of antiselection.

A few companies set minimum age limits at which they will write insurance. These limits are one day, one week, one month, one year, and occasionally higher. Some of these companies do not wish to undertake the infant mortality risk.

what was formerly the average risk in the group becomes a superstandard risk as far as that group is concerned, and the inequity which formerly fell on the new superstandard risks now falls on what had been the average risk. It becomes just as justifiable to remove him from the group into a class by himself, at once creating a new superstandard class in the old group, which becomes justifiably eligible for a group of its own . . . *ad infinitum*. The *reductio ad absurdum* of "select risk" underwriting is a violation of the law of large numbers. Moreover, it can increase the cost of insurance for the average policyholder. As a practical matter, however, select risk underwriting offers a low-rate policy showing an extremely low net cost which makes competitive sales ammunition, especially when it is used as a "typical example" of the cost of the company's whole line of policies.

⁵ Some companies set the maximum age for women at 60.

Age also is important in determining how much life insurance a company will accept on a given life. Usually, companies will write their largest maximum amounts on applicants between ages 25 and 55, with the limits graded downward on each side of this age span. It is felt that the need for life insurance is greatest between the above ages and, too, that the ability to pay for large amounts of life insurance under age 25 is questionable. When policies are issued on infants under age 1, companies often reduce the benefits for the first year.

Age may affect other factors used to determine insurability. For instance, a given degree of overweight after about age 25 (the actual age depending upon the opinion of the company's own medical and underwriting departments) is usually looked upon as less favorable to insurability than the same amount of overweight at younger ages. Underweight, on the other hand, is regarded more seriously at younger ages than at older ages.

In writing non-medical insurance, age is an important factor. Companies usually will not write non-medically beyond ages 40 or 45. Age limits also are established for the writing of disability benefits.

Sex. In general, women are accepted for life insurance on the same basis as men, although this has not always been true. It was commonly considered, even well into the 1920's, that women were not as good risks as men and should either pay a higher rate or not be accepted at all. The "childbirth hazard" is now considered to be so minor as to have no practical effect upon mortality experience, being offset by the more sheltered lives of women.⁶ Moreover, it is statistically observable that women, on the average, live more than five years longer than men. Women have become important buyers of life insurance. Exclusive of credit life insurance, about 15 per cent of the total life insurance in force in the United States today is on the lives of women.

In practical underwriting, except for dependent housewives, sex does not affect the maximum amount of life insurance a company will allow on any one life. Most companies, however, have definite rules about the amount of insurance they will write on dependent housewives. The limit is usually a fixed number of dollars, and it is usually required that the amount be in some proportion to the amount of insurance owned by the husband. This rule is in keeping with the philosophy that the bulk of family premium dollars should be spent for coverage on the life of the breadwinner. If special reasons exist for a disproportionate amount of insurance on the wife (for instance, uninsurability of the husband), the rules usually will be waived, provided the husband has enough income to carry the insurance. Companies may not al-

⁶ To avoid sarcastic annotation in the margin by the feminist contingent, we explain that by "more sheltered lives" we mean, for instance, that fewer women than men work outside the home; hence the statistically average woman is exposed to a smaller number of chances of traffic accident and contagion, to name just two hazards. Moreover, women show a smaller incidence of coronary breakdown, stomach ulcer, nervous breakdowns, and other disturbances generally considered to be aggravated if not created by the vicissitudes of business life.

low a mother to be insured for the benefit of adult children on whom she is dependent and by whom the premium will be paid, since no financial loss will be suffered by her death.

Many companies will not write disability income insurance for women, and those that do, write only relatively short-term benefits on self-supporting females engaged in an occupation requiring them to leave home. Some companies make disability benefit provisions for single women cancellable upon marriage. In some companies the dollar limit of monthly income disability benefits may be lower for women. Also, the maximum age to which the coverage is issued and the maximum age at which disability may occur (in some companies) are lower for women than for men. For example, a company may pay a maximum of \$250 a month for a male and issue the policy up to age 50, requiring that disability occur before age 55. For a female the maximum amount may be only \$150 and the corresponding age limitations may be 45 and 50. Underwriting rules for the waiver-of-premium disability benefit for women usually are not so strict. It is generally available for self-supporting females, and a growing number of companies will write the coverage for dependent housewives. The age limits, however, are lower in some companies for women than for men.

Plan of Insurance. Before the development of substandard underwriting, it was common practice for companies to be considerably more liberal in underwriting higher premium plans of insurance. Higher premium plans require higher reserves per \$1,000 of insurance, and consequently the company has progressively less at risk under these plans. Hence, applicants who would have been considered uninsurable for a continuous-premium whole life plan may have been insured at standard rates under a short-term endowment plan.

The practice of dealing with impairments by restricting the plan of insurance is in use today but on a more limited scale. For example, an applicant with a slight health or physical condition, the effects of which are usually postponed until later years, might be insurable at standard rates under an endowment plan which expires prior to the years in which the impairment is likely to affect mortality. Thus, to illustrate, an overweight person at age 25 might be insurable under some conditions at standard rates under a twenty-year endowment plan because the effects of overweight do not begin to be seriously felt until the middle years. However, this same applicant might be rated substandard for a continuous-premium whole life policy.

Finally, the plan of insurance is important in risk selection because the amount-at-risk is different under different policies; hence, companies often have stricter underwriting rules for certain types of policies. Some plans themselves tend to invite adverse selection. Whereas a given applicant might be eligible for continuous-premium whole life insurance, he might not be eligible for a family income policy, term policy, or a preferred risk contract. The trend in underwriting now, however, is to give less attention to type of policy. Many

companies apply the same selection standards to term insurance as to whole life insurance.

Occupation. Certain occupations are considered extrahazardous and not to be written at standard rates. In the rate book of one company, approximately 750 occupational duties requiring other than standard rates are listed.⁷ Some samples are reproduced below.

	<i>Ratings for</i>		
	<i>Life Only</i>	<i>Disability Income Rider & Waiver of Premium</i>	<i>Double Indemnity Benefit</i>
ABRASIVE MANUFACTURE			
Clay, crushing, furnace, grinding and sizing depts.			
Foremen (supervising only), inspectors	\$2 00	WP only, 150%	200%
Other workers	3.50	Unacceptable	Unacceptable
Other departments			
Foremen and inspectors	Std.	WP only	Std.
Graders, wheel testers, packers, shippers, etc.	Std.	WP only, 150%	200%
Other workers	\$2 00	Unacceptable	Unacceptable
ACETYLENE GAS MANUFACTURE			
Foremen (supervising only), com- pressor engineers, generator ten- ders, skilled workers	Std.	WP only	200%
Other workers	\$2.00	WP only, 150%	Unacceptable
AMUSEMENTS & SPORTS			
Baseball, basketball, golf, tennis, squash players	Std.	Yes	Std.
Circus employees	Unacceptable		
Football and hockey players	Std.	WP only, 150%	200%
Horse racing			
Starters	Std.	WP only, 150%	200%
Trainers (best grade), trotting horse drivers and stablemen	\$2 00	Unacceptable	Unacceptable
Jockeys	Unacceptable		
Others	Inquire		
Prize fighters	Unacceptable		
Racers, auto and motorcycle	Unacceptable		
Wrestlers	Unacceptable		

⁷ Occupational mortality has been improving over the past years, with the resulting tendency among life insurance companies to reduce or eliminate ratings on a number of occupations. Only about 26 per cent of the extra-risk insurance written is rated up for occupation.

Note that, in this listing, some of the jobs may be standard for life insurance alone but substandard or uninsurable for waiver of premium, disability income, or double indemnity riders.

The insurability of various occupations or duties and the ratings they take vary from company to company; however, there is almost always agreement that certain obviously hazardous occupations—of steeplejacks, to give an extreme example, or bartenders, race-car drivers, workers in plants manufacturing explosives, and sand blasters—are to be rated at least substandard. Even here there may be no general agreement among companies as to the extent of ratings, i.e., how much of an extra premium should be charged.

The hazardous nature of any particular occupation arises from a greater incidence of accident in that occupation, from duties or working conditions of a nature which adversely affect health, or from environmental conditions which either attract people of low economic or mental status or place the individuals in contact with people of questionable character.

For underwriting purposes the company is interested in how long the applicant has been in his present job, and, if less than two years, the nature of his previous occupation. This information is necessary since a previous occupation might affect the present state of health of the applicant as well as having a bearing on the moral hazard. A question of concern, too, is whether or not the applicant has an occupational history which suggests a return to a former hazardous occupation. Once a life insurance policy is issued it cannot be rated up should there be a subsequent change in occupation.

Avocations also are important in underwriting because professors may engage in motorcycle racing as a hobby and students may work as bartenders.

Residence. Although health and hence mortality may be adversely affected by various climates and sanitary conditions in different areas, these variations usually are not considered, at least as among locations in North America. Among companies writing foreign business, however, permanent or long-term residence in unhealthful climates or in areas where sanitary conditions are bad may call for either higher premiums or rejection.

If the applicant has changed his residence within the past two years, the company wants to know the place of previous residence. This information is important since it can have a bearing on the present state of health of the insured and may indicate whether or not the applicant may be expected to settle permanently in a location which is undesirable from an underwriting point of view. Also, it has its value for purposes of identification and the investigation of other underwriting factors.

Race and Nationality. Certain races can be shown statistically to have a mortality rate higher than that expected among "Caucasians." Certain nationalities have environment and living standards such that they may produce impairments that continue through one or more generations even after these people migrate to a different country. Since the mortality experience among the non-Caucasian races has been improving at such a rapid rate, race is be-

coming less important as an underwriting factor. In fact, there is a definite trend toward the elimination of special discriminatory treatment of certain races.⁸ A reasonable period of residence in this country, however, is usually required before life insurance may be written on new immigrants. This is to allow them time to adjust to new living conditions and to establish a reliable medical and personal history.

Family and Personal History. The health records of both the insured and his family are considered important in the selection of risks.

In general, family history is important only if it reveals something which might adversely affect the risk, such as cardiovascular renal diseases. Rarely will favorable family history offset the adverse effect of personal history. Age of parents is requested on an application blank since it is considered as having at least some bearing on longevity of the offspring. Death of the parents under age 60 usually is looked upon as an adverse factor; but it is never in itself justification for rejection, affecting underwriting only if early death resulted from something which could be transmitted to children by inheritance or childhood contact.

The personal history of the applicant himself is more directly important in appraising the risk: health record, habits, environment. All these are important in measuring not only the physical hazard involved but also the moral hazard. In fact, the habits, environment, and reputation of the applicant are considered so important that there is an investigation of these history factors by professional and disinterested investigators, commonly employees of organizations conducting a credit investigation business. The nature and significance of the inspection report will be discussed later.

The application blank itself, by including a series of questions, also attempts to determine information relating to the personal history, habits, and environment of the applicant. Heavy drinking, excessive use of drugs, and dangerous living are grounds for rejection. Habits relating to air travel also are important. If there appears to be an *unusual* aviation hazard⁹ the com-

⁸ Some states have laws forbidding any differences in rates based on race, thus confusing social discrimination with rational discrimination. There is no more social discrimination involved in setting a different rate for a race which shows a higher average mortality than there is in setting a different rate for any other statistical reason. It may be contended that setting different rates for a race as a whole discriminates against those members of it who could qualify as standard risks. However, if the number of "standards" in a classification is lower than average (as it is if the entire classification is lower than average), then the cost of selecting the few who qualify becomes higher than the average cost and can be met only by increasing the loading in the premium for expenses of operation. Antidiscrimination laws merely pass the cost of insuring substandard cases along to standard policyholders, which is itself discrimination. This footnote is intended to discuss only the matter of rate discrimination without any comment or implication on the ethics of social discrimination—a subject not within the scope of a text on insurance.

⁹ Travel on commercial airlines, whether scheduled or not, and on military aircraft is not considered to be an unusual aviation hazard. Owners of private planes, those who travel frequently in company-owned planes, and some classes of pilots may be considered to be subject to an unusual aviation hazard.

pany will require more information. The final effect may be an extra premium added to cover the additional hazard. The amount of insurance that will be issued also may be restricted. Life insurance policies do not usually exclude deaths resulting from aircraft accidents, although where there is a severe aviation hazard, such a restriction might be found in policies issued in those states which permit the use of such a clause.¹⁰

Physique and Physical Condition. Physical condition, of course, has a direct effect upon longevity. The insurance companies want to know about an applicant's sight, hearing, heart, arteries, nervous system, lungs, tonsils, teeth, kidneys, etc. They judge the applicant in the light of their knowledge of the effect of any discovered impairment or disorder on longevity in general, and not as it may affect any one individual's life span. Consequently, while a practicing physician might not consider a given impairment as serious in the light of an individual's health, habits, and environment, the life insurance medical department may consider it cause for rating or rejection in view of statistics which show that out of a large group of persons with the impairment, more will die than insurance mortality tables indicate.

For example, the practicing physician, with a chance to observe an individual over a period of time and with full knowledge of all his affairs, might consider an elevation of blood pressure a temporary functional disturbance brought about by a passing condition. On the other hand, the life insurance physician, having no chance to observe the individual over a continuing period of time or positive evidence as to his past history, but having before him only the report of an elevated blood pressure on one or a series of examinations, will give the matter serious consideration. He has statistical evidence that high blood pressure has an adverse effect on mortality in the mass. Even if he knows that the condition is functional rather than organic, he also has evidence that a certain percentage of functional cases will eventually become organic. He cannot judge by the individual case; he must judge by mass experience, for the whole principle of life insurance depends upon the operation of factors in the mass.

In general, impairments can be broken down into three classes: *temporary*, *static*, and *progressive*.

An example of a temporary impairment is a peptic ulcer. An example of a static impairment is an amputation (assuming that it was the result of a localized condition such as an injury and not of a general, progressive disease or disturbance which amputation cannot arrest). Amputation of one limb is usually not cause for rejection or for an extra premium, although it may have an effect upon waiver of premium or upon double indemnity.

An example of a progressive impairment is cancer. Progressive impairments, however, may eventually become static impairments. For instance, cancer, at least in the early stages, often can be completely arrested by X-ray

¹⁰ Disability and double indemnity provisions of these same policies commonly carry some aviation restrictions of their own.

or operation. A history showing a successful cancer operation ten years ago with no evidence of recurrence can be considered in an entirely different light from existing cancer or cancer operated upon recently. Diabetes is an impairment which some companies will consider as changing eventually from a progressive to a static stage. Within the past few years, a number of companies have begun to accept, as substandard risks, diabetic patients whose condition has proved to be completely controllable by the use of insulin.¹¹ At one time diabetics were universally rejected.

The general physique of the applicant is important. Marked variations from the average height and weight, for instance, are considered adverse factors, since such deviations affect mortality in the mass. The distribution of weight is a factor for consideration. A rule of some companies is that if the waist measurement exceeds the expanded chest measurement, an overweight condition is present. Overweight is much more serious than underweight. The effect of underweight and overweight on mortality must be evaluated in the light of personal and family history. Generally speaking, underweight is not seriously regarded as a risk impairment,¹² however, when coupled with a family history of tuberculosis, or when malnutrition is suspected, it will cause careful scrutiny.

Financial Status. Obviously, application for a policy calling for a total premium outlay (adding any existing insurance on the life) completely out of line with the size, source, and stability of the applicant's income is cause for underwriting suspicion. Either the policy is not going to be accepted by the applicant if issued, or there is a good chance that the policy will result in an early lapse. Also there might be speculation involved. Perhaps the applicant has knowledge of a serious impairment which he may be able to conceal. A life insurance company is not interested in speculative risks, and it is not eager to pay either for medical examinations or for the cost of issuing policies only to have them rejected when issued or lapsed before enough premiums are collected to permit the company to recover the acquisition costs in connection with them.¹³

What constitutes overinsurance at any income level is difficult to define. Much depends upon the psychology of the individual. Any two men at the same salary level and with the same responsibility are apt to have different ideas as to what constitutes a reasonable percentage of income to budget for life insurance premiums. Five per cent may be too much for one of them, if his sense of financial responsibility is not deep and his living standards are relatively high. Twenty per cent may seem to another man no burden at all

¹¹ The common practice is to assess a relatively high mortality rating.

¹² Recent studies indicate that the group 10 per cent to 30 per cent underweight shows a better mortality experience past age 30 than do people of average weight. As for overweight, studies show a lesser improvement in mortality over the past years than has been experienced by those of average weight. Overweight, therefore, is becoming more seriously regarded by underwriters.

¹³ See Chapter 20 for discussion of acquisition costs.

if he feels strongly the responsibility of protecting his family and is willing to live conservatively. Here, again, the company must judge on the basis of averages.

Insurance equal to that amount which could be purchased under the continuous-premium whole life plan with 20 per cent of the applicant's income is sometimes used as an arbitrary guide, and is applied to the total amount of insurance in force on the applicant in all companies. An application calling for an amount of insurance in excess of this figure may, in some cases, be considered overinsurance—or at least may be a cause for underwriting concern. At extremely low levels of income, even the 20 per cent rule might produce overinsurance. For example, 20 per cent of a \$200-a-month income leaves only \$160 for living expenses. At extremely high levels of income the 20 per cent rule might also produce overinsurance, since at that level of income 20 per cent may buy an amount of insurance so large as to seem undesirable from an underwriting standpoint. In such cases, however, the agent may supplement the application with unusual facts, or the inspection may reveal an individual set of circumstances which will alter the underwriting attitude toward what constitutes overinsurance. For example, people in high income tax brackets might purchase large amounts of insurance for tax advantages, amounts which otherwise would seem excessive.

The problem of overinsurance in health insurance underwriting will be discussed later in this chapter.

Underwriting rules restricting the amount of insurance allowable on any one insured often are influenced by the ability of the company to get reinsurance. Most companies do not retain the entire face amount of a large policy themselves but reinsure part with other companies.

There has been a noticeable tendency among companies to increase the maximum limits of insurance allowable on a single life. Mortality experience among the so-called "jumbo" risks has improved so rapidly as to make possible this trend toward liberalization of underwriting rules.

Cases involving large amounts of insurance, either in the application or in the aggregate, are usually investigated more thoroughly. If the amount involved is relatively large, say \$50,000, two medical examiners may be used, and if it is very large, say over \$100,000, the company may call for electrocardiogram tracings, chest X-rays, and other supplemental data indicated by the case.

Aside from size, source, and stability of income, the underwriter wants information regarding the general business reputation of the applicant. His credit standing is important in the over-all picture in judging the fitness of the applicant for life insurance. This is especially true when life insurance is issued for credit purposes, i.e., to insure the creditor against the death of the debtor. Insurance on the life of a "dead beat" debtor may be classified as a speculative venture and therefore rejected.

3. SOURCES OF UNDERWRITING INFORMATION.

Five principal sources of underwriting information are: (1) the application, (2) the medical examination or statement of health,¹⁴ (3) the agent's report, (4) the inspection report, and (5) the Medical Information Bureau.

The Application. A reproduction of the application is found in every ordinary life insurance policy.

Part I. This part of the application is filled out by the agent in the presence of the prospect.

One of the first questions asked is *date of birth*. The importance of this question is obvious, since the rate for insurance is based on age. In the case of ordinary insurance, age of applicant for rate purposes is usually considered to be that of his nearer birthday.¹⁵ Hence, for ordinary insurance, age changes midway between calendar birthdays.¹⁶ The applicant is considered aged 25 from the time he is 24 years and 6 months until he is 25 years and 6 months. In the case of industrial insurance, the age for the next birthday is used. The applicant is rated as aged 25 as soon as he passes his 24th birthday. "Age change" is the term used to designate the date on which an individual becomes the next higher age for rate purposes.

Former as well as present address is asked in all applications in order to facilitate the inspection investigation if the applicant is too new in his present location for the inspector to find people who know much about him.

Occupation is asked in order to determine whether or not it is hazardous, and for the same reason, specific duties must be given in addition to "kind of business." If the applicant has been in his present occupation less than two years, he must give his former occupation. Applications also inquire about aviation activities.

The application also asks whether or not there are *negotiations for other policies* now pending or contemplated. The overinsurance picture might change when all policies pending are added to those already in force. Whether the applicant has ever had an *application for life insurance declined or postponed*, or was offered a policy with a rated-up premium or on a plan other than applied for, is an associated question. If the answer is "Yes," space is provided for an explanation. Companies are especially careful of applicants who have a history of rejection.

¹⁴ In non-medical life insurance, the statement of health is the substitute for the medical examination.

¹⁵ A mortality table can be constructed on a basis of last birthday, next birthday, or "nearest" birthday. For the purposes of determining the applicable rate, the age-count rule must match that of the mortality table; i.e., if the table is based on "nearest" birthday, then age must be counted to nearest birthday.

¹⁶ The purchase price for a single-premium life annuity generally is based upon the number of full years plus full months of age which may be completed at the date of issue. The annual premium for a retirement annuity is based upon the nearest age at issue, as in the case of regular life insurance. Cf. Chapter 5.

Applications often ask if the applicant is a *member of the reserve forces* of any branch of the United States Army, Navy, Marine Corps, or the National Guard. By itself, an answer in the affirmative is not considered cause for rejection, rating, or change of plan by most underwriting departments, but may, together with other unfavorable factors, have bearing on acceptance, rejection, or rating.

Any contemplation of *change of occupation* or *change of residence* to a foreign or tropical country must be noted since such a change might materially affect the risk.

The final set of questions in Part I of the application is concerned with the type of policy applied for, the amount, special benefits, methods of paying premiums, how dividends are to be applied (if a participating policy), and the beneficiary designation or designations.

Part I of the application closes (except for the agent's certification, to be discussed separately) with the details of total insurance already in force: year of issue, name of company, amount, and annual disability income, if any. The importance of this information has already been discussed.

Part II. The second part of the application consists of the applicant's statements to the medical examiner as to personal history and is to be completed by an authorized medical examiner for the company in the presence of the prospect. In the case of non-medical policies, Part II consists of "statements in lieu of medical examination." Non-medical policies are those underwritten without the benefit of a medical examination. Medical information as a basis for selection is obtained by means of a questionnaire. The advantage of non-medical insurance to the agent is the elimination of one more obstacle to the sale of insurance. Some people object to the time and trouble involved in submitting to a physical examination. Some even are afraid of physical examinations. Finally, such examinations are expensive, thus increasing the cost of issuance—which is reflected in the rate.

We shall consider the questions in Part II, medical, first. Here the application goes into considerable detail regarding the prospect's past history and present health condition. There is a request for a statement of every illness, disease, injury, and operation since childhood and every physician or practitioner consulted in the last five years. A long series of questions to be answered "Yes" or "No" includes inquiries about such things as X-rays, electrocardiograms, blood tests, other laboratory tests; whether or not the applicant has ever had albumin, sugar, etc.; whether he has ever been in a hospital, clinic, or the like for observation or treatment; whether he has ever changed occupations or residence because of health and whether he has been on a restricted diet within a year; whether he has made a claim for disability or compensation based on sickness or accident; whether his health is impaired, or whether he is in any way deformed or crippled; and whether he has ever had any one of a number of specific diseases or disturbances.

Questions regarding his use of alcohol or narcotics are considered highly important in underwriting the risk.

The family record asks the age, health details, and cause of death (if death has occurred) regarding the applicant's spouse, father, mother, brothers, and sisters.

If the applicant is an adult female, there is a further series of questions regarding pregnancy, maternity, and disturbances indicative of trouble with the female generative organs.

The questions discussed above are those which are asked of the applicant by the medical examiner, and the signature of the insured certifies that the answers have been correctly recorded by the medical examiner. The signature also waives all provision of law forbidding a physician from disclosing any knowledge or information which he has acquired in examining or attending the applicant. This waiver permits the company to make inquiry of any physicians who have attended or treated the applicant in the past. As a practical matter, such inquiries are not made unless it appears that they would have a bearing on the risk.

Non-medical Insurance. Part II of an application for a policy issued non-medically consists of "statements in lieu of medical examination" and covers many of the same questions as those asked by a medical examiner, except that they are asked by the soliciting agent: height, weight, all diseases, illnesses, etc.; physicians or practitioners consulted; X-rays, electrocardiograms, blood tests, albumin, and various specific diseases and disturbances; the use of alcohol and drugs; family records; and the additional questions if the applicant is an adult female. Omitted, of course, are the questions to be answered as the result of a physical examination.

It will be seen from the list of questions that the impression occasionally found among insurance prospects that the physical condition of the applicant is disregarded in the case of a "non-medical" policy is erroneous.

Both the number of companies issuing non-medical policies, and the limits in amount of insurance that will be taken on the plan from any one applicant have increased considerably in the past few years. A principal reason for this trend is the accumulation of favorable experience with non-medical insurance. Other factors are the lack of availability of medical examiners and the increasing cost of medical examinations.

Non-medical insurance was first tried in Canada, where the experiment was made because of the difficulty of getting the medical examiner and the applicant together in rural provinces. Also, it was felt that in the small communities, agents usually knew their prospects well and could do a competent job of preselection. The use of non-medical in the United States was originally limited to rural districts for the same reasons. However, it expanded steadily from the rural areas into the small towns and later into the large cities. With the cursory examination that some physicians give a life insurance

applicant today—and the proof of the cursory nature can be found in the taking of an examination—it seems unlikely that non-medical applicants are any more poorly selected than a number of those who have submitted to medical examinations. This is especially true when the agent himself does a conscientious job of selection. Companies may limit privileges of non-medical to agents who have proved their conscientiousness and their willingness to look at an applicant from a company rather than commission viewpoint.

Other limitations customarily found are the ages at which non-medical will be issued, the maximum amount that will be written, the plans that will be written, and the degree of insurability of the applicant. The practice is to write non-medical insurance up to age 40 or 45 for a maximum limit of \$5,000, \$10,000, or \$15,000. Some companies will write up to \$25,000 at young ages. Other companies restrict the amounts to less than \$10,000 from age 36 up to their maximum, but write \$10,000 or more under age 36. Non-medical usually will not be written on a term plan, nor will it be written for substandard applicants unless the cause of the extra risk grows from an accident hazard arising from an occupation. Studies have indicated that at some ages and for reasonable amounts of insurance on all plans except term, the cost of physical examinations for what appears to be a standard risk exceeds any resulting mortality savings. Currently, about two of every three ordinary policies are issued non-medically.

The Medical Examination. Part III in the application for a medical policy (technically not part of the application) consists of the physician's answers to questions based on his examination of the applicant: marks of identification (to be sure that a healthy person is not being substituted for an unhealthy one), general appearance, apparent age, race, height, weight, body measurements, the findings of a urinalysis, heart action, condition of nervous system, lungs, stomach, kidneys, muscles, joints, glands, eyes, ears, and all such matters. Finally, the examiner is asked if he knows anything in connection with the insured's physical condition, family history, or past health not already recorded which would affect the insurability, and if he does, whether he is sending confidential information on it to the home office. The physician also is asked about the applicant's habits with regard to the use of stimulants and narcotics. Finally, he may be asked if he unreservedly recommends the applicant as a first class, average, or poor risk.

In addition to the medical examination, the applicant's own physician may be contacted for information to help clarify a particular situation.

The Agent's Certification. One of the sources of underwriting information is the agent's report or certification, which appears at the end of Part I of the typical application.

The certification requires the agent to tell how long and how well he has known the insured; if he has any unfavorable information regarding the insured's health, character, habits, and so on; the approximate amount of money the insured is now putting into life insurance; and his estimate of the

applicant's net worth and annual income. An additional report is requested on women concerning the source of income and who will be responsible for the premium; whether the husband carries insurance on his own life and in what amount, and if he carries less than his wife, why he does so; the maiden name of the married applicant and, if she is a widow, the cause of her husband's death. This certification usually requires, also, that the general agent or manager name the soliciting agent in the case and give the names of several references who have known the insured for several years. The company wants to know, too, whether the applicant sought the insurance or was solicited by the agent. Companies are careful of adverse selection when the applicant is unsolicited.

The help of the agent in the selection of risks can be of great value to the underwriting department. If the agent is personally acquainted with the applicant, lives in the same area, and is acquainted with other people who know him, he may be able to provide useful information. In any event, as one company states in its rate book, the following is true:

The final responsibility of selecting risks necessarily rests upon the proper officials at the Home Office. The agent may, however, practice a preliminary selection which will be greatly to his advantage. One measure of an agent's worth to the company is the quality of gilt-edged business which is placed and paid for. In the long run, the agent will earn more money by spending his best efforts in finding prospects who are good risks than in spending this amount of effort in trying to argue the company into taking risks which should not be accepted or by trying to induce the company to reduce a rating.¹⁷

The Inspection Report. An important source of underwriting information on an applicant is the inspection report. The use of inspection reports for supplemental and confirming information on the applicant arises from an original practice of making inquiries among his friends regarding his reputation and habits in order to discover anything of a fraudulent or "off-color" nature about the application. However, both because the territorial activities of companies widened, and because friends often gave prejudiced information, companies began to check applicants through disinterested local correspondents who either knew the applicant or were able to collect information on him from his neighbors and business associates. Some companies eventually established their own inspection departments, and among the larger companies a few of these departments are still in existence.

Today the usual practice is to use a commercial credit investigation agency, or a bureau especially established for the purpose, to make inspection reports on applicants for life and disability insurance policies or applicants for agents' contracts. There are several of these commercial investigation agencies. They provide a means of gathering unbiased information, since

¹⁷ Careful "field underwriting" is even more important in health insurance than in life because of the greater importance of moral risk, which is hard to determine from a written application only.

inspection agencies have no interest, one way or the other, whether the information reported is favorable or unfavorable.

Inspection reports on smaller policies where there are no contradictions or complications in the application are simple and relatively brief. The making of credit investigations is so common a practice in everyday business transactions that an inspection agency will have data on the applicant even before the insurance company makes inquiry. It needs to do only a little checking to bring the data up to date or to find requested information that it does not already have. Among some of the life insurance companies there is a tendency to eliminate inspection reports on small policies as a move toward economy. Not only do inspection reports themselves cost money, but also there are costs involved in handling and using them.

In the case of larger policies or of questionable applications, a more detailed investigation may be requested. The ability of the large commercial credit investigation organization to find obscure facts is sometimes almost incredible.

Questions on the usual inspection report concern the identity of the applicant, his occupational duties, his participation in aviation, his finances, health, habits, and reputation.

The inspection report is also considered the primary source of information relating to moral hazard. In a typical inspection form, this information appears as follows under the classification, "reputation":

Do any of the following apply to this applicant:

Heavy debts?

Domestic trouble?

Drink habits?

Connection with illegal liquor?

Irregular beneficiary?

Is his general reputation as to character and morals good?

If not, give details.

Do you recommend him for life insurance?

Specific comments are asked concerning the exact duties of the applicant's occupation and any part-time occupation; line of business in which he is engaged and how long he has been so employed together with his previous employment record and present financial standing; his marital status, number of children, home surroundings, and standing in the community.

The inspection report is considered an invaluable source of underwriting data. It serves as a good check on information gained from other sources. Sometimes the services of inspection companies also are used to clarify circumstances surrounding questionable death claims.

The Medical Information Bureau. A final source of underwriting data is the Medical Information Bureau, known throughout the industry as the "M.I.B." The Medical Information Bureau, an association of life insurance

companies,¹⁸ is a clearinghouse for information relating to the physical condition of prospects for life insurance. Its purpose is to enable life insurance companies to detect misrepresentations of fact and thus to guard the interests of existing policyholders against imposition and fraud.

The Bureau obtains its information from member companies, who submit reports on all applicants showing any one of a given number of impairments. These impairments may be those affecting the health, any family health history, or habits of the prospective insured. The information which a company reports is limited to its finding of a medical impairment and does not indicate the action taken. The Bureau is never told whether the insurance was issued as applied for, declined, or rated. Moreover, it does not reveal the name of the reporting company.

The fact that a report has been made on the individual simply alerts another company to some impairment which might not otherwise be revealed to that company. Since the underwriting practices of life insurance companies are not the same, it is a common occurrence for one company to accept a risk that has actually been rated or declined by a previous company.

The information on individuals is reported in code by the M.I.B. and is available only to a restricted group of people in a subscribing company and chiefly for the purpose of processing an application for life insurance. The Recording and Statistical Corporation, a subsidiary, records on a card the information provided for each person and makes a duplicate available for the member companies. When a company receives an application, it checks it against its M.I.B. files and uses the data as added underwriting information.

4. RISK CLASSIFICATION.

The evaluation and classification of the risk are functions of the underwriting department. For the most part, the process of evaluation is a matter of correlating information reported about the applicant with its statistically observable effect, if any, on longevity. Often, of course, the effect of any given factor will change over the years as pertinent statistics change. For instance, most life insurance companies once considered any participation in aviation as an unfavorable factor. With current improvements in air safety records, mortality among participants in aviation has decreased. Today, both passenger and flight personnel on world-wide commercial flights are considered as standard risks by most life insurance companies. Again, as previously mentioned, diabetes was once considered cause for rejection. Statistical observation over a number of years now indicates that the malfunction under control does not produce as large a deviation from average mortality as was once thought to be the case.

¹⁸ The M.I.B. was originally organized in 1902 by the Medical Directors' Association. This connection was terminated in 1946 when the M.I.B. was reorganized as an unincorporated association of member life insurance companies. There is no longer any legal connection between the M.I.B. and the Medical Directors' Association.

Formerly, trained clerks used to pass on applications based on their own interpretation of the data submitted. Difficult cases were referred to the supervisors. A few of the small companies still operate in this way. Others use objective rating systems.

Numerical Rating. Wherever human judgment enters in, there is always a residual margin of error despite the amount of training the human mind has been given. Consequently, there has been an effort in the science of underwriting to standardize its operations. Perhaps the most common method of standardization is the numerical rating system.¹⁹

Although there are many variations in use, the basis of the numerical system is the calculation and assignment of debits and credits for the various factors involved in the underwriting of a risk. A standard risk is assumed to have a rating of 100. A factor or condition which is known or suspected to cause a variation from average experience is debited if the deviation is adverse and credited if it is favorable. The extent of the debit or credit of specific items varies from company to company according to that company's own experience and according to its interpretation of published experience. An illustrative example which bears no particular relation to any one company's system follows.

Assume the application of a clergyman. The occupation of clergyman is considered a better than average risk for life insurance. According to statistics available to the company (and remember that this is only an illustration), the mortality of clergymen is 25 per cent better than average. Consequently, on the score of occupation the applicant is assigned a credit of 25.²⁰ However, the application and inspection report reveal that the gentleman went into his profession as a result of a reformation from habits somewhat tipsy. All sources of underwriting information report that he has suffered no relapses in a considerable time. Although, as a given individual, he probably never will, the company has statistics which show that a certain percentage of chronic tipplers will go back and sign the pledge again, "for life, same as the last time." It has further been determined statistically that in any large group of former alcoholics, the mortality will be at least 25 per cent above standard. Consequently, the numerical rating system debits the application 25 or more.²¹

And so the process goes on down the list of underwriting factors, debiting some and crediting others. In the end, the total of the debits is added to 100, and from that total is subtracted the sum of the credits. The resulting

¹⁹ Developed early this century by Dr. O. H. Rogers, Medical Director, and A. H. Hunter, actuary of the New York Life Insurance Company.

²⁰ We like this little illustration even though ratings for occupations are no longer in common use.

²¹ A debit of 25 is usually given where the insured has been a total abstainer for a number of years; much higher debits are given where the reform has been recent.

figure, assuming that the schedule of value of debits and credits is accurate to begin with, will indicate the degree to which mortality can be expected to vary from standard. If the final figure is 95, for instance, then the mortality to be expected on this type of risk is 5 per cent below standard mortality; i.e., 5 per cent better experience is expected than for standard risks; if the total is above 100, say 125, then 25 per cent greater mortality is to be expected. Companies generally will accept, at standard rates, applications scoring not more than 125. Some companies, particularly those not writing extra-risk insurance, may be more liberal.

The values and inaccuracies in the numerical system have long been a subject of discussion and treatises. Old-school medical directors and actuaries were extremely reluctant to agree that risks could be satisfactorily evaluated without individual scrutiny by those trained in medical and actuarial sciences. A particular criticism was that interrelationships among factors will not be evaluated properly, being in combination a greater risk than the sum of them separately indicates, for example, underweight and tuberculosis. Another criticism was that since underwriting is an art and not a science, it is not subject to the exactness of numerical rating. Nevertheless, the numerical rating system has been accepted as the most practical method available and one that can be successfully applied if used intelligently. Various modifications of the numerical system handle cases of interrelated factors more satisfactorily. In borderline cases the application can be submitted to the medical director or the actuary, whereas the great mine run of applications can be processed smoothly by trained and experienced clerks with a minimum of expense and loss of time, and with a more uniform evaluation than even the most learned experts could give, considering the pressure of time and the element of human judgment.

Classes of Risks. Broadly speaking, applicants may be classed either as insurable or uninsurable.

A rate can be figured for any age and any physical condition. Every individual still alive has some life expectancy. Obviously, however, as this life expectancy decreases, the rate for the risk will eventually become too high for the applicant, and, at this point insurance becomes economically impractical. Under these conditions the applicant is, for all practical purposes, uninsurable.

As among companies, who is insurable and who is not depends also upon the extent to which the company issues extra-premium (substandard) policies. Some companies will write substandard insurance up to rates as high as any prospects would ever want to pay in terms of extra premiums. Reinsurance facilities are available which will, as it is sometimes humorously put in the business, "figure a rate for a one-legged World War I veteran with TB." Among those companies that issue substandard insurance, there are some that strictly limit the extent to which they will write it. For reasons of

management philosophy and administration, they may wish not to have too many rated-up cases on their books even though reinsurance facilities are available for them.

Insurable risks divide into three broad classes: standard, substandard, and preferred. Every company, however, does not use all three classifications. Probably less than the majority make any distinction between standard and preferred risks. When a distinction is made between standard and preferred risks, it usually is done for competitive reasons and is limited to one policy. Many of the companies writing so-called preferred risk contracts place a minimum on the size of the policy which they accept in this class. The resulting rate differential often is as much a product of expense savings on large policies as of mortality savings on better than average risks.

Extra-Risk Insurance. Extra-premium charges as a result of specific diseases or impairments are almost as old as *modern* life insurance, which may be said to have begun with the establishment of the Equitable Society of England. In 1762 Old Equitable was charging an additional premium to insure applicants who had suffered from gout, for applicants with hernia, for applicants who had not had smallpox, for applicants with the "female hazard" (women under 50), and for beer retailers.

It was 134 years later, however, before the insurance of substandard lives made its appearance in the United States. In 1896 the New York Life Insurance Company entered the field on an extensive scale following a study of the mortality experience among applicants rejected over the previous fifteen years. As a result of this investigation, a measure of the effect of certain impairments on the mortality of a representative group was devised. The company then issued policies written for an extra premium designed to cover the expense of the additional mortality.

New York Life was alone in the substandard field for a considerable period of time, and it was not until the publication in 1910 of the Medico-Actuarial investigation, a joint project of the Actuarial Society of America and the Association of Life Insurance Medical Directors, that very many companies were willing to issue such policies. Subsequent studies have convinced an increasing number of companies that substandard insurance can be issued on a scientific basis.

Methods of Rating Extra-Risk Insurance. There are several methods of rating substandard risks. They are designed to reflect the nature of the extra hazard since some hazards increase with age, some decrease with age, and others remain constant.

LIEN PLAN. Under the lien plan the standard premium is paid, but less than the full face amount of the policy is payable if death occurs within a certain number of years. This plan could be useful where the extra hazard decreases with age if it were not for its serious limitations. A rather large lien is necessary to offset a small increase in mortality. Also, the lien is placed on the policy during the years when the insurance is needed most. The lien

plan is rarely, if ever, used in the United States today, some states even prohibiting it, although it finds some employment in Canada and Great Britain

RATED-UP AGE. The rated-up age plan assumes that, for insurance purposes, the age of the applicant is a given number of years higher than his chronological age. For example, a man 35 years old may be charged the rate for a man 40 years old. This plan is suitable when the extra mortality increases in amount with age, i.e., when the difference between the standard rate of mortality and the rate of mortality for the substandard group increases with increasing age. Reference to the death rate per 1,000 in the mortality table will illustrate that the differences in the mortality rates between any given age and the rated-up age increase as the ages involved increase. For example, consider the mortality rates per 1,000 at the following ages.

<i>Age</i>	<i>Mortality Rate per 1,000</i>
30	3.56
35	4.59
40	6.18
45	8.61
50	12.32

The difference in mortality rate at age 30 and at age 35 is 1.03 per 1,000. Between ages 35 and 40, it is 1.59; between 40 and 45, the difference is 2.43, and it jumps to 3.71 between ages 45 and 50. Thus, although a rated-up-age policy carries a level premium, the insured would be in effect paying an increasingly higher extra mortality cost each year the policy is in force.

Actually, few impairments increase in mortality rate to the extent of that assumed by the rated-up-age plan. Simplicity is the principal advantage of the rated-up-age plan. It is easily understood and requires no special handling of reserves, cash values, and dividends. In spite of its simplicity, the rated-up-age plan, once widely used, is not too popular today.

FLAT ADDITIONAL PREMIUM. Under the flat additional premium plan, a constant additional premium (an extra premium which does not vary by age) is added to the standard rate. For example, one company charges a flat additional premium of \$5.00 for window cleaners. This means that although the standard rate for continuous-premium whole life insurance at age 30 is \$23.80, a window cleaner at this age would be required to pay \$28.80. On all policies except short-term, the flat additional premium, like the rated-up-age method, provides for an increasing mortality hazard. Since the amount at risk decreases each year, the constant additional premium results in heavier mortality loadings each year, although not necessarily as a percentage of normal mortality. Therefore, when the extra risk is constant, it is necessary to calculate the average extra risk and load the premium accordingly.²² Since the mortality exposure decreases faster under an endow-

²² It is felt that a decreasing extra-premium charge would create too many problems of administration.

ment policy, these policies generally carry a lower extra premium for the same impairment than would be carried by a term or whole life policy.

For the policyholder, the rated-up-age plan is more favorable than the flat additional premium plan when identical premiums are required. Part of the extra premium collected under the rated-up-age plan is used to build higher cash values and, if participating, to pay higher dividends. Cash values and dividends, however, are unaffected by the flat additional premium.

EXTRA PERCENTAGE TABLES. A convenient device for substandard rating is the extra percentage table. Applicants are classified on the basis of the extent to which the mortality of their group exceeds standard mortality. Tables of separate premium scales are then evolved which are based on various brackets of percentages. The percentage tables are used to calculate the amount of the additional premium which will be added to standard rates for various percentage classifications. The effect of this plan may be the same as that of the flat additional premium. In this case standard nonforfeiture values and dividends are used. It is also possible for the percentage tables to be used as a basis for the increase-in-age plan. Here a proper new age is assigned to the applicant that will correspond in mortality experience as nearly as possible to that indicated by the percentage table. Finally, the extra percentage table may be used as the basis for rating without any particular reference to the other two plans. In this event, dividends and nonforfeiture values, as well as the rate, are based on the special mortality indicated by the percentage table. This plan serves best when the extra hazard increases with age.

Extra percentage tables are designated "Table A," "Table B," "Table C," and so on, reflecting 25 per cent increases in mortality above standard (100 per cent).²³ One company may write only through Table C (175 per cent); another may write policies through Table F (250 per cent); but many companies will write through Table P (500 per cent). A few companies will write even up to 1,000 per cent of standard mortality.

The excerpts on page 487 are illustrative of table ratings as published by one company for three different policy forms.

Removal of Ratings. It is common practice for a company to reconsider an extra premium rating for physical impairment in the light of a new medical examination, most frequently paid for by the insured. If the physical impairment is shown to have disappeared completely, the extra rating will be removed from the premium.

It could be contended that removal of a rating for an improvement in physical condition is not valid, for it constitutes selection against the company. In the operation of the insurance principle, the individual is a member of a group. The mortality for the group is based on the average of all entrants and assumes as many in the group who will prove to be better than the

²³ An intermediate classification (AB) is frequently found to reflect 137½ per cent of standard mortality.

**Extra Premium Per \$1,000 of Insurance
at Illustrative Ages
Substandard Table A**

<i>Age</i>	<i>Continuous-Premium Whole Life</i>	<i>20-Payment Life</i>	<i>20-Year Endowment</i>
20	\$1 63	2.21	.78
25	1.71	2 31	80
30	1 98	2.45	89
35	2.42	2 69	1 09
45	3.83	3.68	2.32
55	6 55	6 34	5 02
65	12.01	12.91	12 55

Substandard Table P

20	15.67	30.14	16 79
25	18.64	30.87	17.62
30	22.68	31 80	19.19
35	28 25	33 24	22.32
45	47 01	46 79	40.32
55	85 86	93.35	91.04
65	169.26	136 04	

average as there are those who fall below it. If those whose condition improves are taken out of the group, then the average mortality of the group will become higher.

As a practical matter, however, most companies will reconsider ratings and, if extra premiums are clearly no longer justified, will remove them. The technical error brought about is adjusted in advance by allowing a margin of safety in the calculation of the extra charge.

Removal of the extra rates based on a hazardous occupation is theoretically sound if the insured has changed his occupation to one less hazardous. It is customary, however, to impose a waiting period before eliminating the extra charge in order to make sure that the change is not temporary. A medical examination may be required to determine whether or not the insured's health was affected by his former work.

Extra premiums based on physical impairments are never refunded. The extra premium was charged to pay for the cost of the extra mortality in the group. It has been spent for that purpose and is not recoverable. Extra premiums based on occupation usually are refunded, however, for the periods during which the insured was no longer in a hazardous occupation. Since extra premiums once removed cannot be reassessed, companies must give careful consideration before eliminating them.

Advantage of Extra-Risk Insurance. Substandard insurance is socially desirable since it makes life insurance available to more people than could otherwise obtain it if only standard risks were assumed by the company. About 5,000,000 extra-risk policies are in force for close to \$20,000,000,000 of

insurance. Properly rated, substandard business does not jeopardize the financial strength of the company.

5. THE EFFECT OF SELECTION ON COST.

The foregoing discussion of risk selection reveals clearly its direct effect upon cost. The cost of life insurance is determined by the mortality of the group, interest earnings, and the cost of operation. The higher the mortality, the higher is the cost of insurance. Consistently poor risk selection will, in the case of participating insurance, cut dividends, which means that the existing policyholders will pay more for their insurance. In the case of nonparticipating policies, consistently poor risk selection cannot alter the premium charged any existing policyholder, but it will result in a disproportionate rate increase for new policyholders to make up the loss.

The purpose of selection is integral to rate-making, and upon good selection depends not only adequacy of funds to meet contractual obligations, but also the degree of equity among policyholders.

6. LIMITS OF RETENTION.

All companies set maximum limits on the amount of life insurance they will retain on an individual life. This amount varies from company to company and, in general, is in some proportion to the size of the company: usually, the smaller the company, the lower the limit of retention, since large claims affect small companies much more adversely than they affect large companies. The retention limit of small and new companies might be \$5,000 or even less, whereas the large company might retain well in excess of a hundred thousand dollars.²⁴ Not only does the retention limit vary among companies, but also it may vary within a given company according to age of issue, type of policy, and class of risk. For example, for all types of policies issued at standard rates except term and modified life, a company might retain \$200,000 for applicants between the ages of 21 and 55, but only \$130,000 for those 56 to 60, and \$100,000 for those between 10 and 20. These retention limits might be cut in half or term and modified life policies. For substandard risks, a lower schedule of retention limits might be in effect.

As a practical matter, however, a company does not like to reject an application from a desirable policyholder simply because the amount for which he may wish to insure legitimately is more than the company can handle. If the company refuses to accept the total application, it might end in losing the amount it is willing and eager to insure.

The Nature of Reinsurance. To solve the problem of low retention limits on the one hand and large applications on the other, life insurance companies resort to a process known as reinsurance.²⁵

²⁴ The giant companies may have retention limits of \$500,000 or more.

²⁵ Not all companies engage in reinsurance transactions. A few large companies and some fraternal prefer to limit their writings to those amounts which they feel they can handle themselves.

Under the reinsurance system, a company accepts an application for whatever the amount may be, regardless of whether or not it exceeds the company's retention limit, and issues to the applicant a policy for that amount. There are, of course, gross limits on how much a company will write even with reinsurance.²⁶ It would therefore be more accurate to say a company accepts an application for any amount within reason in view of its underwriting philosophy and the reinsurance facilities it has available. It then takes the amount of the policy in excess of its retention limit to a reinsurance company, which agrees to pay that amount when the policy becomes a claim.²⁷

For a simple illustration of reinsurance, suppose the retention limit of a company receiving an application for \$25,000 is \$15,000. The company which has received the application (called the "direct-writing" company) issues a policy in its name for the full \$25,000 and then reinsures (cedes) \$10,000, which is the amount in excess of its retention limit. If the policy becomes a claim during its first year, the direct-writing company will contribute \$15,000 out of its own funds, while the reinsurer will make up the other \$10,000.²⁸ The payment by the reinsurer, however, is to the company which issued the policy rather than to the policyholder's beneficiary. The full claim check is written and signed by the company which actually issued the policy to the insured.

As far as the policyholder is concerned, there is no difference between a claim paid wholly by the company issuing the policy and a claim paid jointly by that company and its reinsurer. If the reinsurer fails to pay its share of the claim, the direct-writing company still is responsible to its policyholder. The policyholder himself is not a party to the reinsurance agreement, nor does he usually know anything about it.²⁹

Types of Life Reinsurance. Two types of reinsurance are (1) yearly-renewable term and (2) co-insurance.

The Yearly-Renewable Term Plan. Under the yearly-renewable term plan (sometimes called risk-premium reinsurance) the company reinsures only the net amount-at-risk in excess of its retention limit. The net amount-at-risk on any policy is the difference between its face amount and the amount of its terminal reserve. For example, if the terminal reserve on a \$25,000 policy currently is \$5,000, then only \$20,000 is at risk. Thus a company with a net retention limit of \$15,000 in this case would have to reinsure

²⁶ For example, one company has a gross limit of \$500,000 for whole life and Endowment plans issued between ages 25 and 50, but a retention limit of \$250,000.

²⁷ Many companies accept reinsurance, and a number actively solicit it. There are a few companies which do not sell directly to the public at all but deal only in reinsurance.

²⁸ The distribution of the claim burden, should the loss occur in a subsequent year, will depend on how the reinsurance contract is written.

²⁹ For an excellent discussion of reinsurance practices, see W. M. Howard, "Reinsurance of Life Risks," Philadelphia, *Journal of the Society of Chartered Life Underwriters*, Fall, 1954.

only \$5,000 under the yearly-renewable term plan. The reinsurer simply multiplies the net amount at risk under the reinsurance agreement at the beginning of any year by the yearly-renewable term rate for the attained age in order to arrive at the reinsurance premium. In the case cited above, if the insured were now aged 45, then the reinsurance company would charge the yearly-renewable term rate for age 45 and apply it to \$5,000 of insurance. Under this plan the amount of the reinsurance decreases annually as the terminal reserve on the policy increases. The yearly-renewable term plan of reinsurance is preferred by the smaller companies since it enables them to keep a larger amount-at-risk on each reinsured contract, and to retain more of the premium for investment.

The Co-insurance Plan. Under the co-insurance plan the company reinsures the amount of the original contract that exceeds its retention limit and continues this amount of reinsurance in force throughout the life of the contract. For example, if a company with a net retention limit of \$50,000 writes a policy for \$75,000, it will reinsure \$25,000 and continue this amount of reinsurance in force until the policy becomes a claim. The reinsurer will be entitled to one-third of the premium less acquisition and certain other expense allowances and will be liable for a corresponding proportion of claims, nonforfeiture values, and dividends.³⁰ If a company wishes to reinsure on a co-insurance basis with a carrier not licensed in its state, it may use a modified plan whereby the ceding company in effect retains the entire reserve under the contract. Reserves held by reinsurance companies not licensed in the state usually are not allowable as a deduction from the reserve liability of the direct writer. Another reason for using the modified co-insurance plan is the desire of the ceding company to hold and invest the money it collects. The modified co-insurance plan differs from the yearly-renewable term plan in that the amount at risk decreases each year for both the ceding company and the reinsurer, rather than initially for the reinsurer only.

Disaster Reinsurance. The concentration of population in urban areas and the concentration of employees in larger and larger plants, coupled with the writing of group insurance, has increased interest in a type of blanket reinsurance called "disaster reinsurance." This coverage provides a method of stopping losses under individual as well as group policies in case of a multiple-person accident. It supplements the basic, underlying reinsurance plan.

³⁰ In the past, mortality experience under large policies generally was not so favorable as experience under smaller policies. Since dividends usually are based on average mortality experience, reinsurers often found themselves forced to pay dividends in excess of that which was earned by the larger risks which they were reinsuring on a co-insurance basis. Thus, there was a tendency for the reinsurers to prefer the decreasing term basis of reinsurance under which no dividends were paid by the reinsurer. A number of yearly-renewable term plans, however, do include what are called participating agreements under which mortality gains on reinsurance of amounts less than a given figure are shared.

Under the disaster reinsurance plan, the ceding company purchases an amount of reinsurance per accident in excess of a per accident retention limit. For instance, assume the ceding company wishes a retention limit of \$100,000 per accident. It might then purchase disaster reinsurance for a limit of \$3,000,000 per accident. Should a disaster occur in an area or plant in which the ceding company has a number of policyholders and death claims totaling \$2,000,000 result, the entire loss in excess of the \$100,000 per accident retention would be paid by the disaster reinsurance.

The limit of coverage under disaster reinsurance is automatically reinstated following a claim so that the full limit immediately becomes available for a subsequent disaster.

Types of Health Reinsurance. The two most commonly used forms of health reinsurance are quota share and surplus share. Quota share is also sometimes referred to as "co-insurance"; however, strictly speaking, it is not exactly comparable to the term "co-insurance" as used in the case of life reinsurance.

The Quota-Share Plan. Under the quota-share plan, a stated percentage of all benefits of a certain type are reinsured. For instance, a health insurer may reinsure 50 per cent of every loss-of-time benefit or 50 per cent of every medical care benefit. This plan is most often used by companies just starting in business. The quota-share plan is particularly applicable in the case of a company which wants the reinsurer to review the underwriting on every risk and is not primarily concerned with building its premium volume and assets as rapidly as possible. Thus, it is willing to "give away" part of the premium on all its business.

The Surplus-Share Plan. Under the surplus-share plan (sometimes, but confusingly, called "excess plan"), the ceding company reinsures all policies written in excess of its retention limits. The amount of such share is usually determined by the proportion that the amount beyond the retention limit bears to the total amount of such indemnity in force on a particular risk. Assume a policy with a \$10,000 accidental death benefit and a monthly loss-of-time benefit of \$300. Assume further that the company's retention on the accidental death benefits is \$5,000 and on the loss-of-time, \$200. In that case it would reinsure a one-half share of the accidental death and a one-third share of the monthly income benefit.

One variation of the surplus-share type of reinsurance is an arrangement under which a policy written for more than a given amount of coverage is reinsured one-half (or any other share decided in advance); thus, all policies written in excess of a company's retention are reinsured on a uniform basis.

Under surplus share the ceding company is relieved of shock loss exposures but does not, as in the case of quota share, reinsure a portion of every policy issued. It retains the full premium on all the smaller policies.

Other Methods. Other methods of health reinsurance are used on

various occasions to provide automatic reinsurance of individual policies. One method is sometimes called "excess-of-loss-per-person" reinsurance. It is particularly applicable to major medical, which usually cannot be handled on a surplus-share basis inasmuch as all policies are issued for the same amount or for only several different amounts (such as \$5,000, \$7,500, and \$10,000). The usual method is to reinsure major medical on a quota-share basis. However, occasionally it is reinsured for claims in excess of a certain amount per person. Inasmuch as it is generally considered unsound to reinsure 100 per cent of any risk, excess-loss-per-person arrangements are usually confined to a share of the losses exceeding retention. For instance, the ceding company may pay the first \$2,500 of loss per person on \$10,000 maximum indemnity major medical policies and reinsure 80 per cent of the excess over \$2,500.

Disaster reinsurance is also used to apply to all accident forms of health insurance. When so used, the operation of the plan is exactly as described under life reinsurance.

Nonproportional reinsurance, which might be described as an annual guarantee of loss ratios, has received some attention. It can be used with most lines of insurance and has been used in fire insurance. The form presents serious problems, however. In theory, nonproportional reinsurance protects the writing company against unpredictable fluctuations in loss experience such as those produced, for example, by an epidemic. However, excessive loss ratios can also be a result of poor underwriting and other forms of mismanagement. Unless there is a large spread of risk with a long history, the reinsurer would have to take over, almost literally, the operation of the ceding company in order to guarantee its loss ratio.

Reinsurance Agreements. A company may handle each policy on which it needs reinsurance on an individual basis; i.e., the company may wait until it has a need for reinsurance, then "shop" for a reinsurer. This method has the distinct disadvantage of delay in issuing the policy to the applicant. The company may not wish to accept the application until it determines whether or not reinsurance will be available. In the meanwhile, of course, the applicant may withdraw and purchase his insurance elsewhere. This method still finds some use in the life insurance business, particularly in locating reinsurance for that portion of the excess for which the direct writer does not have regular reinsurance contracts.

Because of the disadvantages of case-by-case "shopping," or "street reinsurance," as it is sometimes called, it is customary to provide for reinsurance facilities in advance of need with contracts or "treaties." There are two types of contracts: *facultative* and *automatic*.

Facultative. The facultative treaty is only a little more than a step away from individual shopping, for the reinsurer has the right to accept or reject any reinsurance submitted after a survey of each individual case. The ceding company is under no obligation to submit any business it prefers to retain.

The facultative plan has the advantage of agreement in advance regarding the form in which risks, premium terms, and other details are to be submitted, eliminating the expense of separate policies for each case since the memoranda data coupled with the terms of the contract serve the same purpose.

The disadvantage of the facultative treaty is that the ceding company does not know, in advance, whether it will be able to obtain the reinsurance sought, although by dealing with one reinsurer constantly it comes to know within reasonable limits what that reinsurer will and will not accept.

Automatic. Treaties may also be automatic; i.e., the reinsurer agrees that it will assume liability automatically for the excess over the ceding company's retention limits (up to a certain maximum) on any application acceptable to the ceding company, and the writer agrees to cede all amounts in excess of its retention limit. Thus the policy may be written at once, and the direct writer knows in advance exactly how much reinsurance it will be possible to obtain. More than one reinsurer may be involved in a given reinsurance treaty in which case the basis for sharing the loss among them will be set forth in the treaty.³¹

The maximum reinsurance acceptable to the reinsurer usually bears a definite proportion to the retention limit of the ceding company.³² The proportion decreases as the size of the net retention limit of the ceding company increases. To illustrate: with a \$10,000 net retention maximum, it may be able to obtain automatic reinsurance for four times its own limit. It is then able to issue a \$50,000 policy without any shopping for reinsurance. If, however, it were to raise its net retention limit to \$25,000, the automatic treaty might not provide reinsurance for more than twice the amount of the retention limit, making it possible to issue a policy for \$75,000 without additional reinsurance facilities.

When an application is submitted for an amount which exceeds the maximum available through automatic treaties, the treaty may provide that the excess be submitted on a facultative basis, or it may be necessary for the direct writer to "shop" for it. Reinsurance treaties also are written in combination, being automatic for standard business and facultative for sub-standard business.

Other Reinsurance Services. The use of reinsurance to write amounts in excess of the company's retention limit is not its only use; companies rather commonly reinsure a large part of their substandard business; double indemnity and disability riders often are reinsured. An important reinsurance

³¹ Reinsurance arrangements involving reciprocal agreements among several companies to exchange reinsurance are known as reinsurance pools. Under such arrangements each company is given an opportunity to take as much reinsurance as it cedes.

³² In some situations involving special hazards, a reinsurance company might accept the entire risk if the ceding company does not want any of it. This procedure has made possible the development of adequate exposure units and underwriting experience to handle effectively business which otherwise might have gone uninsured.

service to many companies is the underwriting advice and assistance given by the reinsurer. In other than highly specialized cases, the underwriting services of reinsurance are far more valuable to small than to large companies, which have their own expert underwriting departments. The desire to obtain the benefit of underwriting advice is one factor leading to the use of automatic treaties.

Reinsurance has fostered the growth of new companies, which, of necessity, must have very low retention limits until their growth allows them to make better use of the law of large numbers in predicting their losses.

Reinsurance itself may also be reinsured. The process of reinsuring reinsurance is called *retrocession*.

7. SPECIAL HEALTH INSURANCE UNDERWRITING PROBLEMS.

Because intangibles such as habits, environment, financial responsibility, and character have much more bearing on the incidence, size, and duration of health insurance claims than on life claims, a higher degree of underwriting is necessary, and some extra attention to the underwriting of health is called for here in addition to the general principles as developed earlier in the chapter.

This brief treatment of health insurance underwriting will be broken down into four divisions: (1) the persons involved in health underwriting, (2) the tools of underwriting, (3) factors of importance in health underwriting, (4) handling the substandard risk.

Persons Involved. Three persons are involved in underwriting the health application: the agent, the lay underwriter, and the medical underwriter or department.

The *agent* is much more important in health underwriting than in life. In life insurance the underwriting function of the agent is little more than being sure of the financial standing of the prospect and watching for obvious fraud. Even in the case of the non-medical application, his job is hardly more than that of a reporter. Most of the underwriting of life insurance is done in the home office.

In health insurance, because of the intangibles that are important to proper underwriting, the agent is actually the primary underwriter. As between him and the home office underwriting department, only he knows, sees, and talks with the applicant. He is in a better position to judge habits and attitudes than is the home office. In fact, health underwriting may be said to begin with the agent,³³ a fact it is often hard to get experienced life men who enter the health field to understand.

The *lay underwriter* in the home office handles most of the phases of the

³³ Health underwriting actually begins with the selection of agents. Since an agent solicits business among his natural contacts, the caliber of his applicants will rarely be higher than his own caliber. Underwriting continues through the training and supervision phases of handling agents, also.

underwriting. To the medical department he refers only technical points regarding physical condition. The lay underwriter's job is not only to apply known experience and statistical data to the facts revealed by all sources of underwriting information on the application at hand, but also to attempt to evaluate the interrelationship of these acts and to go beyond the statistics into the human element involved.

The *medical department* may have a hand in formulating underwriting rules and in developing statistics used in underwriting. It also passes on technical questions of physical condition referred to it by the lay underwriter.

In general, the home office underwriting department is concerned not only with evaluation upon application but also with re-evaluation at time of renewal. In optionally renewable forms, such re-evaluation seeks to weed out bad risks, most commonly the moral risk as indicated by excessively frequent claims, unduly prolonged claims, and questionable claims. While the non-can underwriter cannot refuse to renew such risks, re-evaluation is a source of information for future selection.

Tools of Underwriting. The tools of underwriting, from which the underwriting information is obtained, are the application, information from the agent, the inspection report, physicians' reports, and the medical examination, if any.

The *health application* gives the picture of the applicant's occupation, age, sex, health history, etc. These are all prime questions in underwriting, which is the reason they are asked on the application.

Information *from the agent*, facts, impressions, etc., which he may have discovered aside from the questions on the application, are vitally important. As was stated, only the agent has seen and talked to the applicant.

The *inspection report* is disinterested, third-party reporting. The inspector talks to business and social acquaintances of the applicant to confirm details on the application. Inspection reports are almost always called for in non-can and frequent in commercial applications for the larger or broader coverages.

Physicians' reports are obtained where there is any recent history of medical treatment. The attending physician's reports (and sometimes hospital records) are highly important because there is a vast difference between clinical medicine and insurance medicine, as already discussed.

Medical examinations, as stated, are routine for non-can but usually used only for higher limits of broader coverages in the case of commercial.

Factors Affecting Underwriting. The chief factors considered in health underwriting (listed here in what is not necessarily their order of importance) are physical condition, including health history and the findings of the medical examination, if any; occupation; amount and plan of insurance applied for; other insurance owned; age; sex; financial standing; and character.

Physical condition is obviously important in writing insurance which

covers sickness. It is sometimes not understood why it is also important in underwriting accident insurance. While health has little to do with the incidence of an accident, it can prolong the disability resulting from an accident, or intensify it.

Occupation has a direct bearing on the risk. While the introduction of plant safety devices has reduced the direct occupational hazard in many lines of work, there are still very definite differences in claim experience among occupations.

Each company uses a manual or system of occupational classifications. The health insurance rate book carried by the agent lists occupations in alphabetical order and assigns a code to each. Here is an excerpt from a typical commercial rate book:

- AAA *Abstractor*, office duties only
- AAA *Accountant*
- B *Acetylene*, gas plant employee
- B *Acid* plant employee
- B *Actor*, actress, acrobatic, or gymnastic work
- AAA *Advertising*, office or sales duties only

Some companies develop their own classification systems and manuals. Probably most companies use one of the systems developed by either the Bureau of Accident & Health Underwriters or the Health & Accident Underwriters' Conference, intercompany associations that were subsequently merged into the present Health Insurance Association of America. The Bureau manual contains fourteen classifications, coded A through M. The Conference has two manuals, one with eleven classifications and 6,200 listings, coded AA to J, and the other, a simplified classification with 1,380 listings, coded AAA, AA, A, and B.

Non-can occupational classification systems are usually simpler, partly because the higher rate of non-can is in itself selective, limiting the great bulk of applications to the professional, executive, and white-collar classes, and partly because there has never been any real statistical basis for such classifications. An illustrative non-can classification system is as follows:

- (1) Office or clerical work in a stable business
- (2) White collar groups not meeting the requirements for Class 1
- (3) One-man occupations
- (4) Skilled manual workers
- (5) Insurable risks with some occupational hazard.

The agent fills out the application on the basis of the classification applying to the applicant at hand. The home office checks his classification.

The Amount and Plan Applied For. The *amount* applied for is important in determining the possibility of moral hazard. Other insurance already owned is also important because the total amount of coverage an individual has can have a bearing on claim experience. Too much principal

sum can be a source of future trouble. The line between natural and accidental death is often hard to draw. If the amount of death benefit is substantial, it becomes "profitable" for the question of the type of death to be taken to court. The amount of loss-of-time benefits owned is even more important. If it is sufficient to maintain a standard of living reasonably close to that being enjoyed on earned income, the incentive to get well may be lessened, increasing the duration of disabilities, or the benefits may even come to be looked upon as a pension.

Many underwriters hold that the maximum safe amount of monthly benefits where earned income exceeds \$300 a month is one-half of earned income plus \$50. For example, if earned income is \$500, the maximum benefit should be \$300 ($\frac{1}{2}$ of \$500 + 50 = \$250 + 50). Also, there comes a point at which the disability income available is sufficient to live on comfortably regardless of its percentage in relation to earned income. This is particularly true because of high taxes. A \$1,000-a-month disability income free from taxation will maintain a comfortable standard of living for a large family even though the head of the family may have been earning more than twice that amount.

The amount of loss-of-time coverage owned is also susceptible to some subjective evaluation. Assume two men, each earning \$10,000 a year. One lives very frugally, far below a \$10,000-a-year standard; his children are nearly grown; and he has no outside responsibilities. All other things being equal, he would not be as good a risk as the other man who has a higher standard of living (but not in excess of his income), small children, and dependent parents. The first man might have to reduce his standard of living little if he had \$500 a month of tax-free disability income; the second could not possibly maintain his standard and keep up with his financial responsibilities on the same amount.³⁴

The trend at the present time is toward higher monthly income benefit limits.

The *plan* applied for is important since some types of plans can be issued to certain impaired risks, whereas others cannot. For instance, sometimes it is considered proper to issue an accident-only policy where coverage for both accident and sickness could not be issued.

Age affects underwriting because the incidence and duration of disability increase with age. Although, for life insurance purposes, mortality rates increase each year beginning with about age 11, increases in morbidity rates are more by age groupings. For instance, the rate is fairly constant up to age 50, at which time it jumps but remains relatively constant again for the next five or ten years.

Sex is important for two reasons: First, the rate of disability among

³⁴ This is not meant to imply that the more extravagantly a man lives, the better moral risk he is. Note that we said clearly that the second man does not live *beyond* his means. Extravagance is a moral hazard in itself.

women is higher than that for men in the same age brackets. Second, loss-of-time coverages cannot be sold to unemployed women.

Financial standing is indicative of the character of the applicant. Is his credit standing good? Does he evidence integrity in his financial dealings? Is there indication that he "cuts corners" in financial matters—and thus might cut them on claims? Does his financial standing justify the amount of insurance applied for? What is the relation of his earned income to investment income—since loss-of-time insurance is meant to cover earned income?

The *character* of the applicant is one of the most important yet most intangible underwriting factors. What is his marital history? What are his business ethics? What is his general reputation? Does he show evidence of sufficient moral stamina to stand up in adversity? If not, physical adversity or economic adversity may make him an expensive policyholder.

Handling the Substandard Case. If the applicant does not fall into what are termed "standard" ranges, one of several things can be done:

(1) He can be declined. The company can refuse to issue him any insurance at all.

(2) He can be issued reduced limits. As a simple illustration, assume the applicant has applied for \$600 a month disability income benefits but already has \$400. The company's limit of participation is \$800. Instead of the \$600 applied for, he could be offered \$200.

(3) He can be issued a modified plan. As mentioned previously, the company might offer an accident-only policy where it could not offer accident and sickness, or two-year loss-of-time benefits where the applicant has applied for ten-year or to-65 benefits.

(4) He can be offered a longer waiting period. An applicant with a history of severe hay fever who applied for first-day benefits might be acceptable only if the policy contained a waiting period of thirty days before benefits begin for any claim.

(5) He can be offered a waiver. The waiver is a provision attached to the policy excluding the company's liability for a stated condition or conditions. For instance, a prospect with a history of phlebitis might be acceptable for standard with a waiver of liability for phlebitis and varicose veins.

(6) He can be offered coverage at an increased rate. This is a common type of substandard underwriting in life insurance but is not yet common in health insurance. A manual by Roy A. MacDonald³⁵ on this type of underwriting appeared in 1951, and experimentation with it has been going on since that time. At least several large reinsurers offer facilities for substandard rating, and some direct-writing companies are experimenting with

³⁵ *The Underwriting of Sub-Standard Accident & Health Insurance*, the National Underwriter Co. (Cincinnati, 1951) The manual contains not only suggested percentages of premium increases for impairments or medical histories, but also suggested waiver actions.

it on their own retentions. The extent of its use will grow as experience is collected.

Under this plan a percentage increase of premium is added to what MacDonald terms the "pure premium" (i.e., the premium before the addition of administration expenses and acquisition costs). An illustrative section from the MacDonald manual, as modified by a major reinsurer in light of its experience since 1951, follows. (Code symbols and abbreviations have been spelled out here.)

Overweight and Underweight

Medical examination required if more than 25% overweight. See Height and Weight Schedule

Deviation from Standard, Either Overweight or Underweight

	<i>Accident Rate</i>	<i>Health Rate</i>
Up to 25%	Standard	Standard to 15%
26%-40%	10-25%	25-100%
41%-50%	25-50%	100%
51%-60%	100%	150%
Over 60%	Reject	Reject

The more severe ratings should be used for underweights under age 25 or overweights over age 45

Male applicants over 6'4" and female over 6', refer to Medical Board.

Substandard underwriting on an increased premium basis is complicated by the intangible factors in claims. While it is possible to compile statistics on the added hazard of certain conditions, it is more difficult to determine what effect any given disability will have on the moral fiber of differing policyholders.

(7) He may be covered on what is known as a "qualified-condition" plan. Under it, he is issued a regular policy except that benefits payable for a recurrence of a stated condition are restricted and the premium rate increased.

8. SUMMARY.

Risk is the basis of insurance, and the reduction of the burden of risk for the individual is the function of the insurance company. All applicants cannot be accepted, because not all applicants are insurable. Moreover, even as among insurable applicants, there may be wide variation in the chance of loss involved. In order to operate on any practical basis and with any practical degree of equity among policyholders, it is necessary for the company to choose from among the applicants that may be submitted to it only those that fall within the limits assumed in the rate.

The selection of applicants has a very direct relation to the cost of life insurance, since the cost of life insurance is made up of three factors: mortality, interest earnings, and the cost of operation. Improperly selected

applicants will inevitably increase the mortality rate and hence the cost of insurance. Consistently bad selection could wreck a company, since it could lead to a greater mortality than is allowed for in the premium.

Certain intangibles are more important in underwriting the health insurance case than they are in writing the life case, therefore, the process of underwriting will vary somewhat. It is one of obtaining a complete picture of the factors which affect the risk, analyzing those factors, allowing for the adverse ones by the various methods of handling substandard cases, and attempting to foresee the possibility of future unsatisfactory developments among factors satisfactory at the time of initial underwriting. For example, is there any foreseeable chance that economic conditions affecting the applicant's line of work may change to the extent that what is now a satisfactory relationship between income and coverage will in the future be drastically altered?

In health insurance underwriting, it must also be held in mind that the agent is the primary underwriter, for only he knows and comes face to face with the applicant. It must also be remembered that statistical evaluation can go only so far because, more than in almost any other form of insurance coverage, the underwriting is dealing with the human factor.

QUESTIONS FOR CLASS DISCUSSIONS

1. Why is it necessary that an applicant for life insurance meet certain underwriting standards, whereas there are no selection standards applied by the government for Social Security?
2. Why might an applicant be acceptable to one company, yet unacceptable to another?
3. Why is the physical condition of an applicant important in the underwriting of accident insurance?
4. Is the amount of insurance applied for a more important factor in the underwriting of life insurance or disability insurance?
5. What information is needed for the underwriting of life insurance which is not needed for the underwriting of disability insurance? What information is needed for the underwriting of disability insurance that is not needed for the underwriting of life insurance?
6. Why do you suppose that substandard insurance has not developed in the disability insurance field as it has in life insurance? What can disability insurance underwriters do for applicants who are ineligible for standard contracts at standard rates?
7. Your friend Irma has a heart condition so she is not able to buy insurance at standard rates. One agent offers her a policy on a rated-up age plan, whereas a second agent offers a policy on a flat additional premium basis. It so happens that the cost to friend Irma in either case would be \$35 per \$1,000 of

insurance. Which plan would you advise her to take? Would any other method of substandard rating be more beneficial to her than either of these two plans?

8. What are the objections to an automatic reinsurance treaty on the part of the reinsurance company? What can a reinsurance company do to offset any disadvantages resulting from an automatic treaty?
9. For what purposes other than coverage for excess liability might reinsurance be used?
10. What are the economic and social benefits derived from reinsurance?

CHAPTER 20

The Tools of Rate-Making

Throughout this book, constant reference has been made to rates, reserves, and cash values. It is only logical to expect that curiosity might have been aroused as to how they are computed.

As was stated in Chapter 2, the basis of insurance is found in that branch of higher mathematics known as the theory of probability. Fortunately for most of its readers, however, this is not a text in mathematics. It does not seek to instruct potential actuaries. Instead, it seeks only to explain basic rate-making principles so that the general student of life insurance will have at least a fundamental knowledge of the "why's" of rate calculation.

Rate-making in life insurance is close to a science. Rate-making in health insurance, while guided by the same principles, is not. The reason is that while mortality follows patterns predictable within a margin of deviation from tabular that can be handled with slight loadings, morbidity varies widely depending on underwriting, claim practices, and economic conditions. This chapter is concerned principally with the tools of life insurance rate-making. Chapter 21 will give some attention to health insurance rate-making.

Three factors are involved in computing a life insurance rate: mortality, interest, and operating expenses. These factors may be said to be the tools of rate-making.

1. MORTALITY TABLES.

The mortality table is a convenient method of expressing probabilities of living and dying, and is used in rate computations (along with other assumptions¹) to produce sufficient funds to pay claims based on these probabilities.

The mortality table is not, as its form might suggest, the mortality history of a group recorded until there are no longer any survivors. It is, rather, the assembly of a series of relationships between the probable number dying and the number living at any given age. For example, the Commissioners 1958 Standard Ordinary Mortality Table (1950–1954), commonly called the 1958 CSO Mortality Table (see Table 38), shows the relationships between the probable number dying and the number living at each age from zero to 100. To illustrate: of 9,575,636 people assumed to be living at

¹ Interest and expenses.

age 25 the probability is that 18,481 will die before they become 26; of 9,373,807 living at age 35, probably 23,528 will die before 36; and of 6,415 living at age 99, probably all of them will die before 100.

TABLE 38.

Table of Mortality (1950-1954) Commissioners 1958
Standard Ordinary

<i>Age</i>	<i>Number Living</i> (<i>l_x</i>)	<i>Deaths</i> <i>Each Year</i> (<i>d_x</i>)	<i>Deaths</i> <i>per 1,000</i> (<i>1,000q_x</i>)	<i>Expectation</i> <i>of Life</i> (<i>e_x</i>)
0	10,000,000	70,800	7.08	68.30
1	9,929,200	17,475	1.76	67.78
2	9,911,725	15,066	1.52	66.90
3	9,896,659	14,449	1.46	66.00
4	9,882,210	13,835	1.40	65.10
5	9,868,375	13,322	1.35	64.19
6	9,855,053	12,812	1.30	63.27
7	9,842,241	12,401	1.26	62.35
8	9,829,840	12,091	1.23	61.43
9	9,817,749	11,879	1.21	60.51
10	9,805,870	11,865	1.21	59.58
11	9,794,005	12,047	1.23	58.65
12	9,781,958	12,325	1.26	57.72
13	9,769,633	12,896	1.32	56.80
14	9,756,737	13,562	1.39	55.87
15	9,743,175	14,225	1.46	54.95
16	9,728,950	14,983	1.54	54.03
17	9,713,967	15,737	1.62	53.11
18	9,698,230	16,390	1.69	52.19
19	9,681,840	16,846	1.74	51.28
20	9,664,994	17,300	1.79	50.37
21	9,647,694	17,655	1.83	49.46
22	9,630,039	17,912	1.86	48.55
23	9,612,127	18,167	1.89	47.64
24	9,593,960	18,324	1.91	46.73
25	9,575,636	18,481	1.93	45.82
26	9,557,155	18,732	1.96	44.90
27	9,538,423	18,981	1.99	43.99
28	9,519,442	19,324	2.03	43.08
29	9,500,118	19,760	2.08	42.16
30	9,480,358	20,193	2.13	41.25
31	9,460,165	20,718	2.19	40.34
32	9,439,447	21,239	2.25	39.43
33	9,418,208	21,850	2.32	38.51
34	9,396,358	22,551	2.40	37.60
35	9,373,807	23,528	2.51	36.69
36	9,350,279	24,685	2.64	35.78
37	9,325,594	26,112	2.80	34.88
38	9,299,482	27,991	3.01	33.97
39	9,271,491	30,132	3.25	33.07
40	9,241,359	32,622	3.53	32.18
41	9,208,737	35,362	3.84	31.29
42	9,173,375	38,253	4.17	30.41
43	9,135,122	41,382	4.53	29.54

Table of Mortality (1950-1954) Commissioners 1958
Standard Ordinary (continued)

<i>Age</i>	<i>Number Living</i> (l_x)	<i>Deaths</i> <i>Each Year</i> (d_x)	<i>Deaths</i> <i>per 1,000</i> ($1,000q_x$)	<i>Expectation</i> <i>of Life</i> (e_x)
44	9,093,740	44,741	4.92	28.67
45	9,048,999	48,412	5.35	27.81
46	9,000,587	52,473	5.83	26.95
47	8,948,114	56,910	6.36	26.11
48	8,891,204	61,794	6.95	25.27
49	8,829,410	67,104	7.60	24.45
50	8,762,306	72,902	8.32	23.63
51	8,689,404	79,160	9.11	22.82
52	8,610,244	85,758	9.96	22.03
53	8,524,486	92,832	10.89	21.25
54	8,431,654	100,337	11.90	20.47
55	8,331,317	108,307	13.00	19.71
56	8,223,010	116,849	14.21	18.97
57	8,106,161	125,970	15.54	18.23
58	7,980,191	135,663	17.00	17.51
59	7,844,528	145,830	18.59	16.81
60	7,698,698	156,592	20.34	16.12
61	7,542,106	167,736	22.24	15.44
62	7,374,370	179,271	24.31	14.78
63	7,195,099	191,174	26.57	14.14
64	7,003,925	203,394	29.04	13.51
65	6,800,531	215,917	31.75	12.90
66	6,584,614	228,749	34.74	12.31
67	6,355,865	241,777	38.04	11.73
68	6,114,088	254,835	41.68	11.17
69	5,859,253	267,241	45.61	10.64
70	5,592,012	278,426	49.79	10.12
71	5,313,586	287,731	54.15	9.63
72	5,025,855	294,766	58.65	9.15
73	4,731,089	299,289	63.26	8.69
74	4,431,800	301,894	68.12	8.24
75	4,129,906	303,011	73.37	7.81
76	3,826,895	303,014	79.18	7.39
77	3,523,881	301,997	85.70	6.98
78	3,221,884	299,829	93.06	6.59
79	2,922,055	295,683	101.19	6.21
80	2,626,372	288,848	109.98	5.85
81	2,337,524	278,983	119.35	5.51
82	2,058,541	265,902	129.17	5.19
83	1,792,639	249,858	139.38	4.89
84	1,542,781	231,433	150.01	4.60
85	1,311,348	211,311	161.14	4.32
86	1,100,037	190,108	172.82	4.06
87	909,929	168,455	185.13	3.80
88	741,474	146,997	198.25	3.55
89	594,477	126,303	212.46	3.31
90	468,174	106,809	228.14	3.06
91	361,365	88,813	245.77	2.82
92	272,552	72,480	265.93	2.58
93	200,072	57,881	289.30	2.33

<i>Age</i>	<i>Number Living</i> (l_x)	<i>Deaths</i> <i>Each Year</i> (d_x)	<i>Deaths</i> <i>per 1,000</i> ($1,000q_x$)	<i>Expectation</i> <i>of Life</i> (e_x)
94	142,191	45,026	316.66	2.07
95	97,165	34,128	351.24	1.80
96	63,037	25,250	400.56	1.51
97	37,787	18,456	488.42	1.18
98	19,331	12,916	668.15	.83
99	6,415	6,415	1,000.00	.50

What's in a Mortality Table? Table 38 is the Commissioners 1958 Standard Ordinary Mortality Table. It is made up of five columns: "Age," "Number Living," "Deaths Each Year," "Deaths per 1,000," and "Expectation of Life."

The "age" column runs from zero through 99. Why does it stop at age 99? Why not include ages 100 and beyond? According to the table, out of 6,415 people alive on their 99th birthday, 6,415 will probably die before they reach 100 years of age. In other words, the table states that probably all the people reaching age 99 will die before they reach 100. Since it is presumed that no one will live to be 100, there is no point in extending the table beyond age 99. There are some authenticated cases of people living past age 100, but statistically they are so few that they can be ignored for purposes of rate-making.² The age at which all are dead is called the "limiting age."

The "Number Living" column starts with a group of 10,000,000 individuals at age zero. Any number, however, could have been used as a starting figure and any age as a starting age. (For instance, the American Experience Mortality Table, published in 1868 and based on mortality experience covering the years 1843–1858, started with 100,000 individuals at age ten, and was extended in 1900 to age zero.) The number used at the starting age chosen is called the "radix."

The figures in the "Deaths Each Year" column are the probable number of people out of the given group at that age who will die before reaching their next birthday. This figure is the other half of the relationship between the number living and the number dying. It is the difference between the figures for two successive ages in the "Number Living" column, since the figures in the "Number Living" column are reduced each year by the probable number dying during the previous year.

By reducing the "number living" by the "deaths each year," the table makes it easy to determine the probable number of deaths over a period of years out of any starting group. For example, using the 1958 CSO to determine the probable number dying over a five-year period out of 9,575,636 living at age 25, all that is necessary is to subtract the number living at age

² Annuity tables, which are based on the experience of annuitants, run to higher ages—to age 109 in one table.

30 (9,480,358) from the number living at 25. The remainder is 95,278, the probable number dying in the five years.

In theory, the "Deaths per 1,000" column is similar to the "Deaths Each Year" column. The figures in both of these columns are the "death part" of the living-dying relationship. However, in the "Deaths Each Year" column, the "living part" of the relationship is the *number assumed to be living* at the beginning of the year, whereas in the "Deaths per 1,000" column, the living part of the living-dying relationship is always 1,000.

The final column, "Expectation of Life," is the average number of additional years which those at any given age can be expected to live. For example, based on the 1958 CSO Table of Mortality, life expectancy at age 97 is 1.18 years. The table shows that there are 37,787 living at the beginning of age 97. Out of this group, 18,456 will probably die between ages 97 and 98; 12,916 between 98 and 99; and 6,415 between 99 and 100. The average age of death of the group is computed as follows:

<i>Number Dying</i>		<i>Age of Death</i>		<i>Aggregate Age</i>
18,456	×	97.5	=	1,799,460.0
12,916	×	98.5	=	1,272,226.0
6,415	×	99.5	=	638,292.5
<u>37,787</u>				<u>3,709,978.5</u>

The total aggregate age (3,709,978.5) divided by 37,787 (the number of individuals in the group) equals 98.18, which is the average age of death for the group. Life expectancy of the group, therefore, is 1.18 years.

It should be noted that, contrary to the general impression of a large part of the public, the life expectancy of any one individual does not enter into the computation of his life insurance premium in any manner. For example, the life expectancy at age 25 is 45.82, 1958 CSO; but the probability of death in the next year is 1.93 per 1,000. The rate for a five-year term policy issued at age 25, if based on life expectancy, would be zero because the life expectancy at that age exceeds the five-year term by more than forty years. Yet during this five-year period, 95,278 out of 9,575,636 will die, and the premium must allow for these deaths.

Life expectancy figures, however, have some uses. They are used in figuring taxable income under annuities, as explained in Chapters 5 and 17, they are used in comparing mortality tables and in studying improvements in longevity among the people or in comparing longevity among countries, sexes, and races; and they are used to measure the duration of "life expectancy" term policies as discussed in Chapter 3.

Constructing a Mortality Table. Possession of any one of the following sets of figures will make it possible to compute the remaining three columns in a mortality table: (1) the number of people surviving at each age from an original group of individuals; (2) the number of people dying during each

age from an original group of individuals; (3) the number of people dying at each age out of the number living at the beginning of the age. The following examples will illustrate how mortality tables are constructed.

Example 1: From an original group of individuals, the number living at the ages tabulated below is:

<i>Age</i>	<i>Number Living</i>		<i>Age</i>	<i>Number Living</i>
27	3,179,474		32	3,146,482
28	3,173,147		33	3,139,403
29	3,166,706		34	3,132,129
30	3,160,119		35	3,124,602
31	3,153,388			

The first four columns of a mortality table (ages 27 through 34) may be constructed from these data as follows:

First, compute the "Deaths Each Year" column: Since 3,179,474 individuals were living at the beginning of age 27 and only 3,173,147 were living at the beginning of age 28 (the end of age 27), then 6,327 must have died during the year. The process is repeated for each of the other years as indicated below:

<i>Age</i>	<i>Living Beginning of Year</i>		<i>Living End of Year</i>		<i>Deaths During Year</i>
27	3,179,474	—	3,173,147	=	6,327
28	3,173,147	—	3,166,706	=	6,441
29	3,166,706	—	3,160,119	=	6,587
30	3,160,119	—	3,153,388	=	6,731
31	3,153,388	—	3,146,482	=	6,906
32	3,146,482	—	3,139,403	=	7,079
33	3,139,403	—	3,132,129	=	7,274
34	3,132,129	—	3,124,602	=	7,527

Then compute the "Deaths per 1,000" column by dividing the number dying during the year by the number living at the beginning of the year, and multiplying the answer by 1,000. At age 27, 6,327, the number dying, is divided by 3,179,474, the number living. This gives 00198995, which represents the chance of death for any one member of the group. When this figure is multiplied by 1,000 it gives 1.99, which is the expected number of deaths from each 1,000 members of the group. This process is repeated for each age group as shown below:

<i>Age</i>	<i>Deaths Each Year</i>		<i>Number Living</i>		<i>Deaths per 1,000</i>
27	6,327	—	3,179,474	× 1,000 =	1.99
28	6,441	÷	3,173,147	× 1,000 =	2.03
29	6,587	÷	3,166,706	× 1,000 =	2.08
30	6,731	÷	3,160,119	× 1,000 =	2.13
31	6,906	÷	3,153,388	× 1,000 =	2.19
32	7,079	÷	3,146,482	× 1,000 =	2.25
33	7,274	÷	3,139,403	× 1,000 =	2.32
34	7,527	÷	3,132,129	× 1,000 =	2.40

The following are the completed first four columns of the table:

<i>Age</i>	<i>Number Living</i>	<i>Deaths Each Year</i>	<i>Deaths per 1,000</i>
27	3,179,474	6,327	1 99
28	3,173,147	6,441	2 03
29	3,166,706	6,587	2 08
30	3,160,119	6,731	2 13
31	3,153,388	6,906	2 19
32	3,146,482	7,079	2.25
33	3,139,403	7,274	2 32
34	3,132,129	7,527	2.40

The "Expectation of Life" column is omitted because it cannot be computed unless the table is completed to the age at which all members of the group are dead ("limiting age"). In the case of the 1958 CSO Table, the limiting age would be 100.

Example 2. Raw data used in the construction of a mortality table usually are collected by age classes. From the following raw data, several steps are necessary to complete a section of a mortality table (from ages 35 through 40).

<i>Age</i>	<i>Number Living</i>	<i>Number Dying</i>
35	300,000	753
36	250,000	660
37	750,000	2,100
38	630,000	1,896
39	540,000	1,755
40	630,000	2,224

First, list the ages. Next, figure the "deaths per 1,000." The process is identical with that used in the example above.

<i>Age</i>	<i>Deaths Each Year</i>		<i>Number Living</i>		<i>Deaths per 1,000</i>
35	753	÷	300,000	× 1,000 =	2.51
36	660	÷	250,000	× 1,000 =	2.64
37	2,100	÷	750,000	× 1,000 =	2.80
38	1,896	÷	630,000	× 1,000 =	3.01
39	1,755	÷	540,000	× 1,000 =	3.25
40	2,224	÷	630,000	× 1,000 =	3.53

In constructing the table it is possible to assume any number as the number living at age 35; consequently 100,000 will be used as the radix. If 100,000 were living on their 35th birthday and 2.51 per 1,000 died before reaching 36, then 251 would be the probable number of deaths during the year. The probable number surviving to age 36 would be 99,749. The probable number dying during age 36 would be $99,749 \times 2.64$ or 263. The process would be continued until the calculation of the number dying for age 40. The completed table is below.

Age	Number Living	Deaths Each Year	Deaths per 1,000
35	100,000	251	2.51
36	99,749	263	2.64
37	99,486	279	2.80
38	99,207	299	3.01
39	98,908	321	3.25
40	98,587	348	3.53

Use of Mortality Tables. The following examples will illustrate how the mortality table is used in computing projected claims under life insurance contracts.

Example 1: What would be the charge (excluding interest and expenses) ³ for a one-year term policy issued at age 35 assuming 1958 CSO mortality? This table shows that if 9,373,807 individuals were insured at age 35, 23,528 would probably die before they reached age 36. Furthermore, if these individuals were insured for \$1,000 each the projected claims would amount to \$23,528,000. The proportionate share of these claims per policyholder would be \$2.51.⁴

Example 2: What would be the charge (excluding interest and expenses) for a \$1,000 single-premium pure endowment at 65 issued at age 30? ⁵ If 9,480,358 pure endowments were sold, the probable number of claims would be 6,800,531. Since each claim would amount to \$1,000, total claims would be \$6,800,531,000. The cost per policyholder would then be \$6,800,531,000 ÷ 9,480,358 or \$717.33.

The first step in computing the premium for any type of insurance or annuity contract is to tabulate the amount of projected claims. A mortality table is essential for this task.

Mortality tables also are important in the valuation of reserve liabilities and for the calculation of nonforfeiture values. Companies might, for example, use the 1958 CSO Table for the valuation of reserves, but a less conservative one for computing premiums and nonforfeiture values. Especially is this true in figuring premiums for a nonparticipating policy where a dividend cannot be used to refund excess premiums resulting from the use of tables with ultraconservative safety cushions.

Safety Margins. Not only must a mortality table be based on adequate statistical data, but it should also provide a safety margin to allow for unpredicted increases in the death rate and for temporarily adverse mortality fluctuations.⁶ When the table is to be used to establish minimum standards for the legal reserves, appropriate margins must be allowed over average

³ The role of interest and expenses in premium computations is deferred until later in the chapter.

⁴ \$23,528,000 — 9,373,807.

⁵ A pure endowment is a policy which pays nothing if the insured dies before reaching endowment age but pays the face amount upon reaching that age.

⁶ Insurance companies, for example, witnessed a temporary but drastic mortality fluctuation during the influenza epidemic of 1918–1919.

company experience to make the table safe for all companies—those with liberal underwriting as well as those with strict underwriting, those national in scope as well as those sectional in scope, those insuring a large proportion of females as well as those insuring males almost exclusively.

In some of the older mortality tables, a safety margin was assured by using data gathered from a period which had higher mortality rates than the present or than was anticipated in the future.

The newer tables, however, are first computed from relatively recent mortality data, to which is added a safety margin computed mathematically. (This is sometimes called “enriching” the table.) For example, the following are the death rates per 1,000 from the 1958 CSO Mortality Table, first without and then with safety margins.

<i>Age</i>	<i>Without Safety Margins</i>	<i>With Safety Margins</i>	<i>Age</i>	<i>Without Safety Margins</i>	<i>With Safety Margins</i>
20	84	1.79	50	6 71	8.32
25	.93	1.93	55	10.93	13 00
30	1.08	2.13	60	17.56	20 34
35	1 41	2 51	65	27 61	31.75
40	2.36	3.53	75	63 80	73 37
45	4.03	5.35	85	140.12	161.14

Annuities. On first thought, one might assume that a given mortality table would work as well for annuities as it does for life insurance. An analysis of the question, however, reveals four reasons why this is not true.

First, the safety factors which are built into a life insurance mortality table would have the opposite effect if the table were to be used for annuity rates. They would result in the establishment of an unsafe rate rather than produce a margin of safety, by projecting a lower survival rate than indicated by the basic data.

Second, while a decreasing trend in mortality rates is a factor of safety for life insurance rate computation, it tends to make the table unsafe for annuities. If a life insurance policyholder lives longer than projected in the table, the company has a gain from mortality; however, for every year that annuitants live longer than the table predicts, the company has a loss from mortality.

Mortality rates have been decreasing. For example, based on mortality statistics for the general population, the life expectancy at birth in 1939–1941 was 63.6 years. By 1949–1951 it had risen to 68.1 years, and by 1957 to 69.3 years. Although some of this increase was brought about by an improvement in infant mortality, analysis shows that more than one-half of it was a result of a decline in the death rate beyond age 25. Life expectancy at age 65 also has increased during this period from 12.8 in 1939–1941, to 13.8 in 1949–1951, and to 14.0 in 1957.

Third, in an annuity table, companies find it necessary to distinguish between the sexes. Mortality rates for females are much lower than for

males.⁷ Since women are heavy buyers of annuities, companies take this mortality differential into consideration. This difference usually is handled by rating women down four or five years, thus avoiding the necessity of using two tables.⁸

Until recently, life insurance companies have made no differential in life insurance rates based on sex. Currently, however, some companies are offering policies to women for lower rates than for men, perhaps establishing a trend. The differential generally is restricted to policies written for not less than a given minimum amount such as \$5,000.⁹

Fourth, mortality among people who purchase annuities is lower than among those who purchase life insurance—for at least two reasons: (1) They are a select group as to environmental conditions. Single-premium annuities can be purchased only by people with capital, and the possession of capital often indicates that the owner has had the opportunity to enjoy superior environmental conditions and better medical care. The annuity income continues these environmental advantages to the group, thus creating a better mortality experience among them in general.¹⁰ (2) People are not likely to buy annuities unless they are in good physical condition. This is not necessarily the case in life insurance, even though companies do make an effort to select carefully and charge extra for substandard applicants.

Annuity mortality tables will, therefore, show fewer deaths and a greater expectation of life at any given age than will mortality tables used to compute rates and values for life insurance. For example, the Annuity Table for 1949—Male (1939–1949) projects a life expectancy at age 65 of 15.01 years, whereas the 1958 CSO Table projects only 12.90 years. Two factors make this difference even greater than it appears. (1) the 1958 CSO is based on more recent data and (2) the 1958 CSO data include female as well as male mortality experience. Since mortality experience is improving, and since women live longer than men, the tables would show an even greater difference if the basic data were comparable.

Types of Mortality Tables. A two-way classification system of mortality

⁷ According to the Industry Actuarial Advisory Committee to the N A I C, Subcommittee on Deficiency Reserves and Mortality Tables Review, the average level of ultimate mortality on males is about 5 per cent higher than the corresponding level for the mixture of males and females included in standard ordinary mortality experience.

⁸ For example, a woman aged 65 would be assumed to have the same death rate as a man aged 60 or 61.

⁹ One reason companies for so long did not differentiate between life insurance rates for men and women of the same age is that policies on women usually are for a lower average amount. The added expense of issuing small policies, it was thought, offset the lower mortality cost.

¹⁰ It is often said that the way to live to a ripe old age is to purchase an annuity. While the longer life of annuitants is largely a result of the preselection described, there is an element of validity in the statement. The ownership of an annuity not only assures better environment and health care but also relieves the mind of one of the most ruinous of all worries of later years—whether money will last or whether the individual will have to become an object of charity, public or private.

tables may be used. First, they may be separated into general population, insured lives, and annuitants. Second, they may be divided into select, ultimate, and aggregate.

A *general population* mortality table is one based on population statistics. The National Office of Vital Statistics periodically prepares a group of mortality tables showing mortality rates in the country among males and females, among white and colored, among rural and city dwellers, and among native and foreign-born in various sections of the country. The data from which these tables are prepared are not entirely accurate because of errors made by the census takers and processors and because of inaccurate and inadequate information given by the people. These tables are not used in rate-making and computing reserves, not only because they contain errors, but also because life insurance companies select risks rather than insure all applicants. Consequently, mortality experienced by the companies should be less than that stated in the general population tables. If poor risks were not rejected, adverse selection probably would produce mortality experience higher than the general table.

Table 39 shows the variation between general population statistics and those based on insured lives.

TABLE 39.

Deaths per 1,000		
<i>Age</i>	<i>1958 CSO Basic ^a (Without Safety Margin)</i>	<i>1949-1951 Census</i>
20	.84	1.35
30	1.08	1.79
40	2.36	3.68
50	6.71	8.76

^a These mortality figures are based on mortality statistics for the period 1950-1954. Were they based on the 1949-1951 period used in the census figures, there would be even greater disparity, since mortality experience is improving.

A number of tables have been developed from statistics on *insured lives* and on the *lives of annuitants*. The data upon which these tables are based are usually accurate because they come from the records of the companies. Insurance companies, by the very nature of their business, must maintain accurate records of birthdates and dates of death. Where necessary, insurance companies, by pooling experience, can develop sufficient data to produce a credible mortality table.

As stated above, tables based on insured lives may be select, ultimate, or aggregate.

A *select* mortality table shows the rate of mortality at age of entry and for each year thereafter among a group of recently selected lives. Two groups of insured individuals, both aged 35, would not be expected to experience

the same rate of mortality if one group was insured ten years ago and the other last year. The second group will still show the effect of selection based on physical, occupational, and moral standards. However, when these same two groups reach age 40, five years hence, their mortality rates would probably not differ greatly. Thus, from a practical standpoint, there would seem to be no need to continue the select character of the table any further. It is estimated that the beneficial effects of selection wear off in about five years.

Table 40 is an example of a select table. Notice that the table shows age [35], [35] + 1, [35] + 2, and so on, rather than age 35, 36, 37.¹¹ When the five-year select period has expired, the age will be age 40, not [35] + 5. At that age the benefit of selection is assumed to have worn off, and select data are replaced with ultimate experience. Ages [36] through [36] + 4 and [37] through [37] + 4 are also shown for comparison.

TABLE 40.

American Men Select Table
(Ages 35, 36, & 37)

<i>Age</i>	<i>No. Living</i>	<i>No. Dying</i>	<i>Deaths Per 1,000</i>
35	100,000	316	3.16
[35] + 1	99,684	428	4.29
[35] + 2	99,256	454	4.57
[35] + 3	98,802	474	4.80
[35] + 4	98,328	514	5.23
36	100,000	323	3.23
[36] + 1	99,677	441	4.42
[36] + 2	99,236	469	4.73
[36] + 3	98,767	495	5.01
[36] + 4	98,272	539	5.48
37	100,000	333	3.33
[37] + 1	99,667	455	4.57
[37] + 2	99,212	489	4.93
[37] + 3	98,723	517	5.24
[37] + 4	98,206	567	5.77

Select tables are used by companies in making comparisons of their experience with that of other companies and in analyzing their own experience as among years. They are also used by some companies in computing non-participating premiums.

An *ultimate* mortality table shows the rate of mortality at various ages for lives beyond the select period; i.e., it shows the rate of mortality after the effect of selection has worn off. The mortality rate for a group aged 35 on an ultimate table will show the expected mortality under policies which

¹¹ [35] + 1 is the symbol to show that the age of issue was 35 and that one year has elapsed.

have been in force for more than five years. The 1958 CSO Table, as well as other tables used in making participating (and some nonparticipating) rates and establishing minimum reserve standards, are ultimate tables.

Aggregate tables are developed from data on all insured lives with no distinction made as to how long the lives have been insured. Recently selected lives are combined with lives which have been insured for many years. Aggregate tables are not used in life insurance rate-making because the ultimate tables give the companies a little extra margin to help with the high first-year expenses involved in selling and issuing the policy.

A *basic* mortality table is one based on insurance company experience without the inclusion of a safety factor. Since 1934 a group of major companies has maintained a continuous mortality investigation on the basis of their combined experience. The statistics so obtained are used periodically by the mortality committee of the Society of Actuaries to construct basic tables. They are used also by company actuaries to construct tables to serve as standards with which they can compare their own company's experience. In addition, they are used to calculate premiums for nonparticipating insurance. Both select and ultimate tables are prepared. Select mortality rates are provided each year for the preceding year. Ultimate mortality statistics are provided in five-year age groups.¹² In addition to select and ultimate mortality data for ordinary insurance, mortality investigations are made of the experience on juvenile ordinary policies, policies of large face amounts, group life insurance, aviation, and, when applicable, war. The main purpose of these investigations, upon which are based the resulting tables, is to study mortality trends and to serve as standards of comparison of mortality experience among companies. Since frequent changes in the mortality tables used for premium calculations, reserve computations, and nonforfeiture values are neither practical nor necessary,¹³ such changes are made only at long intervals.

Development of Mortality Tables. "Traditionally, the actuary has interested himself primarily in the measurement of the span of human life and the determination of the probabilities of death and survival over specific periods. From the first crude table of mortality constructed by Halley, of comet fame, through the speculations on the possibilities of a mathematical law resulting in the empirical formulae of Gompertz and Makeham, to the modern actuarial techniques, we have seen a constant and continuing search for information which would reduce the risk of error in the making of

¹² For policies in force six to fifteen years, only standard, medically examined issues are used. The experience during the sixteenth and subsequent policy years covers all standard issues, medically examined and non-medical.

¹³ Not necessary because gains from mortality are (1) anticipated in calculating the rate, (2) returned as dividends, or (3) both; not practical because of the high cost of computing new rates and issuing new policy forms and rate manuals based on them. The importance of a new table has far more significance in the regulation of reserves than in the computation of a premium rate, as discussed later in this chapter.

estimates as to future mortality experience. Accuracy in these estimates is necessary in our business to reduce the risk of financial loss to the insurer and to increase the degree of fairness with which the losses insured against are apportioned among those insured."¹⁴

Life Insurance Tables. Until 1900 the actuaries' table, more precisely known as the English Seventeen Offices Table of 1843, was commonly used in the United States. This table was based on the experience of British companies.

After 1900 and until 1948 the American Experience Table was generally used. This table is chiefly the work of Sheppard Homans, who used as his basis the mortality statistics of a period from 1843 to 1858 taken from the experience of the Mutual Life Insurance Company of New York, of which he was at one time actuary. The table was first published in a schedule attached to an act passed by the legislature of the State of New York on May 6, 1868. It was the first table based upon American insured lives. A number of old policies are still in force today which were issued on the American Experience Mortality Table. Age 96 is the limiting age on this table.

Substandard or extra premium insurance for policyholders of impaired health has been made possible largely through a study of the experience on policies issued by some thirty-nine companies between 1885 and 1927. This study was made by the Actuarial Society of America and the Association of Life Insurance Medical Directors through what is known as the "Medico-Actuarial Mortality Investigation."

The American Men's Table, the American Women's Table, the Canadian Men's Table, and the Canadian Women's Table were published in 1918 and were based on the work of the Actuarial Society of America with the co-operation of the American Institute of Actuaries and the National Association of Insurance Commissioners. Experience in these tables covers the years 1900-1915 on policies issued from 1843 to 1914. They show more favorable mortality experience, especially at younger ages, than is reflected in the American Experience Table. While these latter tables were recognized and authorized by the Insurance Department of Canada and the provinces, they never came into general use in the United States. They were used by a few companies in the late 1930's and in the 1940's, particularly in making rates for nonparticipating ordinary insurance and for group insurance. The smaller companies in particular successfully fought attempts to require the use of these tables for reserve valuation. It was felt that the safety margins in these tables were inadequate, and their use would have decreased the safety margin in rates and would have led to increased reserves and surrender values.

Two modern mortality tables in use today are the Commissioners 1941 Standard Ordinary and the 1941 Standard Industrial Tables, adopted by most

¹⁴ Alfred N. Guertin, "Actuarial Trends in the Life Insurance Field," University of Connecticut, *Insurance Lecture Series*, Spring, 1952.

states as the basis for reserves and nonforfeiture values in the mid-1940's.¹⁵

The CSO Table was compiled by the Committee to Study the Need for a New Mortality Table, of which Alfred Guertin, then Actuary for the New Jersey Insurance Department, was chairman. The committee was appointed in 1936 as a committee of the National Association of Insurance Commissioners. The table is based on mortality experience of a large group of companies between 1930 and 1940, and is weighted to give an adequate safety margin to companies which use it.

The 1941 Standard Industrial Table is based on the industrial mortality statistics of the Metropolitan Life Insurance Company from 1930 to 1940, and is also weighted to give an added margin for safety. It soon replaced the Standard Industrial Table of 1907 (1896-1905)¹⁶ as the basis for computing reserves and surrender values for industrial policies.

The newest mortality table is the 1958 Commissioners Standard Ordinary Table developed by the National Association of Insurance Commissioners and the Society of Actuaries. While the impetus for the work on this table grew from the deficiency reserve problem,¹⁷ the Industry Advisory

¹⁵ Many efforts were made to encourage the development and adoption of a new mortality table long before the development of the 1941 CSO Tables. The opponents, however, had always been successful in blocking the moves. The chief arguments for a new table were: (1) the American Experience Table was out of date; (2) it did not represent the average of all companies; (3) a new table would show the fallacy of the contention that companies were overcharging by using the old tables; (4) the public demanded a new table; (5) professional critics of life insurance—meaning people who made money out of yellow-journalism attacks on the business—often made a point of the use of out-of-date mortality tables without explaining how the premium is adjusted through the dividend formula (and in other ways) to reflect more recent experience. The principal objections to a new table were: (1) the present table served the purpose well enough because the companies knew how to allow for its error, so there was no need in going to the expense of developing a new one; (2) a newer table might create serious problems for new companies since it might result in higher reserves; (3) a new mortality table might give less margin for expenses under New York and Wisconsin laws since it will give lower net premiums; (4) a new table might cause some companies to be more selective in their underwriting, which some people argued would not be in the public interest; (5) lower net premiums resulting from new mortality tables might cause the public to demand lower gross premiums. For a good discussion of arguments over the desirability of a new mortality table and other matters relating to the history of mortality tables, see R. Carlyle Buley, *A Study in the History of Life Insurance*, New York, Appleton-Century-Crofts, Inc., 1953.

¹⁶ This table was also based on Metropolitan's experience.

¹⁷ Improvements in mortality experience have made it possible for companies to reduce their premiums. Minimum reserves, however, had to be maintained on the basis of the 1941 CSO Table at $3\frac{1}{2}$ per cent. In New York, the maximum interest assumption is 3 per cent. The formula for computing reserves (Chapter 23) is the present value of projected claims less the present value of projected net premiums. In New York the amount of each premium used in the projection must not be less than that yielded by using the 1941 CSO mortality assumptions at 3 per cent. If the company charges a gross premium less than this amount, it will be required to set up a reserve to offset the deficiency in future premiums. For example, at age 35 one company charges \$18.92 per \$1,000, non-par for its continuous-premium whole life policy. The net level premium for this policy figured on the basis of 1941 CSO at 3 per cent would be \$19.13. This policy, therefore, would require a deficiency reserve equal to the present value of a life annuity

Committee to the N.A.I.C.'s Subcommittee on Deficiency Reserves and Mortality Tables Review concluded that an important need for a new mortality table existed regardless of the deficiency reserve problem. In their June, 1958, report they pointed out that the 1941 CSO Table was actually less representative of current experience than the American Experience Table was at the time the 1941 CSO Table was developed.

The 1958 CSO Table is based on a mortality table called X_{17} , which was devised by the Society of Actuaries. The basic data underlying the table are the combined ultimate mortality experience on \$170,000,000,000 of standard ordinary insurance of fifteen large companies during the period between 1950 and 1954 policy anniversaries and involved death claims of nearly \$2,000,000,000. The basic table is a graduated¹⁸ mortality table constructed from these data. The unadjusted death rates at the young adult ages run less than half of those of the 1930–1940 study used for the 1941 CSO Table, and in no case are they more than 81 per cent of the earlier rates.

The basic unadjusted mortality table was compared with individual company experience to study deviations, using both the fifteen large companies whose figures made up the table and also the experience of thirty-three smaller companies. This comparison showed a range of actual to projected deaths of from 65.3 per cent in the company with the most favorable experience to 115.7 per cent in the company with the least favorable experience. It was agreed that mortality rates representing average company experience, without margins, would not be appropriate in a mortality table that was to be used by all companies as a basis for determining their policy reserves. Accordingly, a margin was adopted ranging from a low of 15 per cent (ages 64–93) to a high of 236.1 per cent (age 10).¹⁹ Comparison of the fifteen companies' combined experience showed actual deaths to be about 83.6 per cent of those projected in the adjusted table.²⁰ The lowest percentage for any of the fifteen companies was 79 per cent and the highest was 88 per

due of 21 cents a year figured at 3 per cent interest and 1941 CSO mortality. This would amount to \$4.34 initially, and will decrease each year. If the reserve were based on the 1958 CSO Table at 3 per cent, no deficiency reserve would be necessary since the net level premium figured on this basis would be only \$16.29. (If you do not completely understand this note but get the general idea, this should be sufficient for now.)

¹⁸ Raw mortality data do not reveal a continuous and regular rise in the death rate from low to high ages. Especially are there likely to be irregularities at the very young and very old ages. To iron out these irregularities and to produce a graduating mortality curve, actuaries must adjust the raw data by applying one of the formulas developed for this purpose. The procedure is known as graduation, and the table that results is called a graduated table.

¹⁹ The percentage margins vary widely among ages. For example, at ten-year intervals the margins are: age 0—11.8 per cent; 10—236.1 per cent; 20—113.1 per cent; 30—97.2 per cent; 40—49.6 per cent; 50—24.0 per cent; 60—15.8 per cent.

²⁰ Thus, from an aggregate point of view, the average percentage margin for all ages combined is: $100\% - 83.6\%/83.6\%$ or 19.6%. This compares with a 16.4% margin on the 1941 CSO Table.

cent. Comparing the thirty-three companies, the range was much wider, going from 48.8 per cent to 92.7 per cent.

A separate table, 1958 CSO-A, was prepared by adding a loading of .75 deaths per 1,000 to 130 per cent of the 1958 CSO Table mortality rates. This table is specifically designed to provide for both the higher mortality experienced by some companies under the extended-term nonforfeiture benefit and the expense of maintaining this benefit in force.²¹

The Commissioners 1958 Standard Ordinary Mortality Table was recommended by the N.A.I.C. to the states as a permissive standard for the valuation of reserves and surrender values until January 1, 1966, and as a mandatory minimum standard after that date. The committee also recommended that the companies be allowed to use an age down to three years younger for female lives. (This is called a "rate-down," or, specifically in this case, "a three-year rate-down for women.")

Annuity Tables. Although several other annuity tables have been developed (the McClintock Table for 1896, the American Annuitants' Table for 1920, and the Combined Annuity Table for 1928), the most important ones are the 1937 Standard Annuity Table, the Annuity Table for 1949, and the Group Annuity Table for 1951.

The 1937 Standard Annuity Table is the one most extensively used even though mortality improvements have made it obsolete. Adjustments are made in premium calculations by rating ages down (for example, a person age 65 may be rated as though he were 63) and using low interest assumptions. The basic data from which this table was constructed were the experience of clerical employees covered under group life insurance during 1932-1936 for those ages below 60. For ages 60 and above, the experience of individual annuitants was used. The table does not include a margin for safety, even though the trend toward increasing longevity would seem to make a safety margin more important than in life insurance tables.

The Annuity Table for 1949 is significant because it introduced for the first time projection factors to reflect continued improvements in mortality rates. The experience with employees covered under group annuities in the major companies was used for ages 55 and below (male; 50 female), and the experience of annuitants covered under individual immediate straight life annuities was used for ages over 55. The basic data were based on the early and middle 1940's but were adjusted to 1949. Two sets of projections were developed. Scale A is based upon the continued improvement of mortality at the same annual rates as in the past; Scale B projects a lower rate of improvement at younger ages and a higher rate of improvement at older ages than has taken place in the past.²² The table without the projection factors is

²¹ Although state laws typically allow an assumption of higher mortality for this purpose, many companies do not choose to do so.

²² The theory of Projection Scale B is that improvements in mortality in the early years has already brought the rate so low that further decreases should not be expected at the same rate. The rate of improvement at the higher ages, however, should be ex-

used by some companies in fixing individual annuity rates and in figuring life incomes under life insurance settlement options.

The Group Annuity Table for 1951 (Ga-1951) for ages under 56 was developed by applying projection Scale B for one year to the annuity table for 1949. For ages over 65 the 1946-1950 intercompany experience of retired group annuitants, adjusted for three years under projection Scale B, was used. Extrapolation²³ was applied to arrive at ages 56-65.

A safety margin was added by reducing male mortality rates by 10 per cent and female rates by 12½ per cent. Projection Scale C was developed to keep the table current. This scale projected greater improvement than Scale B because mortality rates among group annuitants are higher than among individual annuitants and therefore can be expected to improve at a faster pace. The Ga-1951 Table in modified form is used by several life insurance companies in computing group annuity rates.

2. INTEREST.

Because premiums are paid in advance of claim payments, insurance companies have money to invest and upon which to earn interest. This is reflected in a lower cost of insurance.

Types of Interest. The two types of interest are simple and compound

Simple Interest. Under simple interest, the interest is paid to the investor each year as it is earned, and the investor has the problem of reinvesting it if he so desires.

For example, if \$100 is invested at 2½ per cent *simple* interest, the earning is \$2.50 a year and is actually paid to the investor. The amount of interest also is \$2.50 in each of the following years. As a result, the amount of simple interest earned in four years, for example, is four times \$2.50 or \$10.00.

Compound Interest. Under compound interest, the interest earned each year is added to the principal and reinvested for the next year. In this way the principal constantly increases each year by the amount of the interest earned during the preceding year. Consequently, since the size of the principal increases each year, so does the amount of interest earned.

For example, if \$100 is invested at 2½ per cent *compound* interest, the return is \$2.50 the first year. During the second year, interest is earned not only on the original principal of \$100, but also on the previous interest earning of \$2.50, which has been reinvested. Thus, in the second year, the interest earned would be \$2.56. For the third and fourth years, the interest would be \$2.63 and \$2.69. For the four years the total interest earned would be \$10.38. This compares with \$10.00 earned at *simple* interest.

pected to increase since this is the group that is most likely to benefit from advances in medical science.

²³ A statistical process for estimating a quantity which depends on one or more variables by extending the variables beyond their established ranges.

Since it is assumed that life insurance companies keep their interest earnings reinvested until funds are needed to pay claims, compound interest is assumed in the calculation of life insurance rates and reserves.

Table 41, page 521, shows the value of \$1.00 invested at $2\frac{1}{2}$ per cent compound interest for the years indicated.²⁴

PRESENT VALUE. Compound interest amount tables show how much \$1.00 at a given rate of interest will accumulate to at some specified future date. Present value tables show the reverse; i.e., they show how much (assuming a given rate of compound interest) must be on hand now in order to accumulate to \$1.00 at a specified date in the future. For example, at $2\frac{1}{2}$ per cent compound interest, in order to have \$100 at the end of one year, \$97.56 must be invested. If \$100 is needed at the end of ten years, then at $2\frac{1}{2}$ per cent compound interest, \$78.12 must be invested now.²⁵ Table 42 shows the present value of 1 due in the number of years indicated at $2\frac{1}{2}$ per cent. The present value concept is an important concept in life insurance mathematics because the present value of future obligations and the present value of future premiums to be collected must be equated.

Use of Interest in Rate Computation. The method of figuring the cost of two different types of insurance contracts, if interest and expenses are excluded, has already been explained. Interest can now be introduced into the picture. Under the assumption that claims are paid at the end of the year and premiums are paid at the beginning of the year,²⁶ it becomes necessary to determine how much would be charged at the beginning of the period, assuming a given rate of compound interest, in order to have enough to pay claims projected under the mortality assumptions used.

Example 1: Assuming 1958 CSO at $2\frac{1}{2}$ per cent, how much (excluding expenses) would be charged for a \$1,000 one-year term policy issued at age 35?

²⁴ The formula for these values is $S = P(1+i)^n$ where S is the amount; P , the principal; i , the rate at which interest is to be compounded; and n , the number of years involved.

²⁵ The present value of \$1.00 due one or more years from now is found by the following formula:

$$P = \frac{S}{(1+i)^n}$$

P is present value, S is the sum (in this case \$1.00), i is the rate at which interest is to be compounded, and n is the number of years. Thus the present value of 1 due five years from now at $2\frac{1}{2}$ per cent is:

$$P = \frac{1}{(1+.025)^5} \text{ or } .88385.$$

Just as in the practical use of algebra, no one ever stops to calculate a logarithm (or a square root), even though he might have been taught how to go about it, so no one in the practical use of present values ever stops to calculate them as has been done here. Instead, tables of present values are available. The actuarial symbol for the present value of 1 is v^n . v^n equals $1/(1+i)^n$.

²⁶ These assumptions will be examined later. Cf. Chapter 21.

TABLE 41.

Amount of 1 at $2\frac{1}{2}\%$ Compound Interest $(1 + i)^n$

Year	$2\frac{1}{2}\%$	Year	$2\frac{1}{2}\%$	Year	$2\frac{1}{2}\%$
1	1.02500	16	1.48451	31	2.15001
2	1.05063	17	1.52162	32	2.20376
3	1.07689	18	1.55966	33	2.25885
4	1.10381	19	1.59865	34	2.31532
5	1.13141	20	1.63862	35	2.37321
6	1.15969	21	1.67958	36	2.43254
7	1.18869	22	1.72157	37	2.49335
8	1.21840	23	1.76461	38	2.55568
9	1.24886	24	1.80873	39	2.61957
10	1.28008	25	1.85394	40	2.68506
11	1.31209	26	1.90029	41	2.75219
12	1.34489	27	1.94780	42	2.82100
13	1.37851	28	1.99650	43	2.89151
14	1.41297	29	2.04641	44	2.96380
15	1.44830	30	2.09757	45	3.03790

TABLE 42.

Present Value of 1 at $2\frac{1}{2}\%$ Compound Interest $(v)^n$

Year	$2\frac{1}{2}\%$	Year	$2\frac{1}{2}\%$	Year	$2\frac{1}{2}\%$
1	.97561	16	.67363	31	.46512
2	.95181	17	.65720	32	.45377
3	.92860	18	.64117	33	.44270
4	.90595	19	.62553	34	.43191
5	.88385	20	.61027	35	.42137
6	.86230	21	.59539	36	.41109
7	.84127	22	.58087	37	.40107
8	.82075	23	.56670	38	.39129
9	.80073	24	.55288	39	.38174
10	.78120	25	.53939	40	.37243
11	.76215	26	.52624	41	.36335
12	.74356	27	.51340	42	.35448
13	.72542	28	.50088	43	.34584
14	.70773	29	.48866	44	.33740
15	.69047	30	.47674	45	.32917

Reference to the mortality table shows that if 9,373,807 individuals are insured, probably 23,528 will die before they reach age 36. In other words, if each of these individuals has a \$1,000 policy, the projected claims for the group would be \$23,528,000. The process thus far is identical with that used in the mortality examples; however, to take interest into consideration, it is necessary to find the present value of these claims; i.e., to find out how much money is needed now to have \$23,528,000 at the end of the year. To find this figure, multiply the amount of claims by the present value of 1 for one year at $2\frac{1}{2}$ per cent compound interest. This computation ($\$23,528,000 \times .97561$) gives \$22,954,152.08. To obtain the cost per policyholder, divide the present value of projected claims by the number insured (9,373,-

807). The answer (\$2.45) is the net premium for a \$1,000 one-year term policy at age 35, 1958 CSO, $2\frac{1}{2}$ per cent.

The above computation is shown below in tabular form.

Age	Projected Claims	Amount of Insurance	Amount of Projected Claims	Years of Interest	Present Value Factor	Present Value of Projected Claims														
35	23,528	\$1,000	\$23,528,000	1	.97561	\$22,954,152.08														
<table> <tr> <td></td><td><i>Present Value of Projected Claims</i></td><td></td><td><i>Number Insured</i></td><td></td><td><i>Premium</i></td><td></td></tr> <tr> <td></td><td>\$22,954,152.08</td><td>÷</td><td>9,373,807</td><td>=</td><td>\$2.45</td><td></td></tr> </table>								<i>Present Value of Projected Claims</i>		<i>Number Insured</i>		<i>Premium</i>			\$22,954,152.08	÷	9,373,807	=	\$2.45	
	<i>Present Value of Projected Claims</i>		<i>Number Insured</i>		<i>Premium</i>															
	\$22,954,152.08	÷	9,373,807	=	\$2.45															

Example 2. How much would be charged (excluding expenses) for a \$1,000 pure endowment at age 65 issued at age 30, assuming $2\frac{1}{2}$ per cent compound interest and 1958 CSO? If 9,480,358 pure endowments are sold, the projected number of claims will be 6,800,531. Since each of these policies is for \$1,000, the total amount of projected claims would be \$6,800,531,000. Next, find the present value of these claims by multiplying this figure by the present value of 1 at $2\frac{1}{2}$ per cent compound interest for thirty-five years (.42137). The reason for the thirty-five-year discount period is that the premiums are to be collected at age 30 but benefits will not be paid until age 65 (end of age 64). As a result, premiums will earn interest for thirty-five years. This computation ($\$6,800,531,000 \times .42137$) gives \$2,865,539,747 as the present value of projected claims. Next, divide this figure by the number insured (9,480,358) to get the single premium charged with each policyholder. The result is \$302.26.

The above computation is shown below in tabular form.

Age	Projected Claims	Amount of Insurance	Amount of Projected Claims	Years of Interest	Present Value Factor	Present Value of Projected Claims														
30	6,800,531	\$1,000	\$6,800,531,000	35	.42137	\$2,865,539,747														
<table> <tr> <td></td><td><i>Present Value of Projected Claims</i></td><td></td><td><i>Number Insured</i></td><td></td><td><i>Premium</i></td><td></td></tr> <tr> <td></td><td>\$2,865,539,747</td><td>÷</td><td>9,480,358</td><td>=</td><td>\$302.26</td><td></td></tr> </table>								<i>Present Value of Projected Claims</i>		<i>Number Insured</i>		<i>Premium</i>			\$2,865,539,747	÷	9,480,358	=	\$302.26	
	<i>Present Value of Projected Claims</i>		<i>Number Insured</i>		<i>Premium</i>															
	\$2,865,539,747	÷	9,480,358	=	\$302.26															

Effect of Interest and Mortality Assumptions on the Premium. Either a change in interest assumptions or a change in mortality assumptions will affect the size of the premium. A change from a $2\frac{1}{2}$ per cent to a 3 per cent assumption, for example, would decrease the net annual premium on a continuous-premium whole life policy from \$12.55 to \$11.28, using the 1958 CSO Table. The higher the rate of interest, the greater will be the contribution by investment earnings and the lower will be the direct cost to the policyholder. A change from higher to lower mortality assumptions also will decrease the premium. The net annual premium at age 25 for a continuous-premium whole life policy would be \$20.50, using CSO 1941 assumptions at $2\frac{1}{2}$ per cent compared with \$17.67 on the CSO 1958 assumptions at $2\frac{1}{2}$ per cent. The lower the mortality rate, the longer will be the average period

over which the company will hold the money and earn interest on it. Also, the lower the mortality rate, the higher will be the survival rate among premium payers, and consequently the greater the average number of premiums the company will collect from each policyholder. Thus, each premium can be lower than would be the case under higher mortality assumptions. Premiums, therefore, vary inversely with changes in interest assumptions and directly with changes in mortality assumptions.

3. EXPENSES.

The premium computations illustrated in earlier paragraphs provided for enough money to pay projected claims based on given interest assumptions. They allowed nothing for the cost of doing business nor for profits in a stock company.²⁷ They are *net* premiums²⁸ and were computed by taking only two factors into consideration, mortality and interest. The \$2.45 computed in Example 1 is the *net* premium for a one-year term policy issued at age 35. Likewise, the \$302.26 computed in Example 2 is the *net* premium for a pure endowment at 65 issued at age 30.

Only a subsidized insurance plan like National Service Life Insurance can operate on the basis of net premiums. A mutual insurer would have to add a charge for handling the insurance, paying the taxes, and for building various contingency funds to meet adverse fluctuations in interest earnings and mortality experience. A stock insurer would need, in addition, a margin for profits. Providing an allowance in the premium for these charges is called loading.²⁹ The loading added to the net premium gives the *gross* premium, which is the premium quoted in the rate books of the companies.

The technique of loading involves three objectives. (1) to cover all expenses and contingencies, (2) to have the funds for expenses when needed,³⁰ and (3) to spread the cost equitably among the policyholders.³¹ Loading is actually a problem in cost accounting rather than actuarial science.

Items of Loading. Loading consists of four main items.

Acquisition Costs. By far the largest of all expenses to be considered

²⁷ The use of conservative mortality and interest assumptions gives a margin for expenses or for profits upon which some companies rely to a degree in fixing their final premium rates

²⁸ The terms "gross" and "net" as used here must be distinguished from the same terms as applied to (1) participating premiums before and after dividends or (2) premiums including and excluding commissions. A Commission on Insurance Terminology has been created by the American Association of University Teachers of Insurance to work on the problem of establishing uniform terminology that will not overlap

²⁹ This term is trade argot and disliked by some who consider that it connotes to the public an unnecessary addition to the premium. However, it is so widely used in all discussions of rates that there seems to be no good way to avoid it

³⁰ As will become clear later (Chapter 23), practical difficulties are involved in following this objective under level-premium plans.

³¹ As will be seen later, in participating insurance some of these objectives are shifted in part to the dividend scale and handled only in a rough way in the loading formula.

are those in connection with putting new business on the books. For example, on a \$1,000 policy issued at age 25, total costs of acquisition might be in the neighborhood of \$20.00 while costs in connection with the administration of the policy after the first year may drop to \$2.25 or \$2.50. Acquisition costs could be loaded into the premium in the year incurred. However, this plan would involve a premium differential, making the premium for the first year substantially higher than subsequent premiums. While such a plan is used occasionally, particularly in the case of mutual assessment and some health insurance policies, it is usually not considered the best practice from the standpoint of life insurance selling. Companies do not like to emphasize the high acquisition cost nor does the public like to pay heavy first-year premiums. Hence costs of acquisition are amortized over the total premium-paying period, and a level amount is added to the net premium each year.³²

General Overhead Loading. All expenses designated as general overhead in any type of business—clerical salaries, furniture and fixtures, rent, management salaries, etc.—must be considered. The allocation of these costs is unaffected by the size of the premium, probably little affected by the face amount of the policy, but most likely is affected by the number of policies.

Loading for Contingency Funds. Once a level-premium legal reserve policy has been issued, the premium cannot be changed, even should unforeseen contingencies make the rate in the policy inadequate. Assessment insurance plans can take care of such contingencies, theoretically, by levying an extra charge against the policyholders. Legal reserve companies, however, allow for the possibility of increased expense or decreased earnings by establishing various contingency funds.

The amount of loading for contingency funds will vary in relation to the type of policy and the amount-at-risk; i.e., the excess of the face amount over the reserve.

Immediate Payment of Death Claims. One of the items which might be added to the net premium in arriving at the gross premium is a charge to offset the loss resulting from the fact that death claims are paid throughout the year rather than at the end of the year as assumed in the net premium computation.

Relying on large numbers, it is safe to assume that death payments will be reasonably uniform during the year, and therefore that on the average all death claims will be paid six months before the end of the year, or about six months earlier than is assumed in calculating net premiums. This means that in any year there will be a loss to the company of approximately one-half of one year's interest on the funds used to pay mortality costs for that year. Allowance may be made for this loss by loading it into the gross premium, or it may be considered in the computation of the net premium by using continuous functions which allow for conditions which are closer to fact. It may

³² The negative difference between the first-year reserve and the amount of premium left after acquisition costs and death claims are paid is charged against surplus. The surplus account is replenished from subsequent premiums.

even be ignored since rate structures have enough "fat" to take care of it.

Methods of Loading. In discussing acquisition costs, contingency funds, and general overhead loading, three classifications into which expenses of operation may fall have been considered. These are: (1) Expenses which vary with the size of the premium. These include, for example, agents' commissions and premium taxes. (2) Expenses which vary with the face amount of the policy. Examples here can be found in underwriting cost. Insurers spend more money obtaining underwriting information for large policies than for small ones. Also, it frequently costs more to service large policies because they may require special settlement agreements, beneficiary arrangements, and other estate planning features. (3) Expenses which are constant regardless of the size of the premium or the face amount of the policy. Examples are record-keeping, collecting the premiums, paying the claims, and general overhead. The first step in loading is to determine into which of the three categories each type of expense falls.³³

Obviously, it would be inequitable to lump all operating expenses and divide by the number of policies in force, because each policy does not contribute equally to company expenses. Just so, it would be inequitable to assess all loading in proportion to the size of the premium or the face amount of the policy. Hence, the system of loading used by any one company is a combination of a percentage of premium, percentage of face amount, and, in some cases, a fixed amount per policy. When this latter factor is used, premium rates per \$1,000 will vary with the size of the policy. Some companies, for example, achieve a graded premium scale by charging a higher premium for the first \$1,000 of insurance and a lower but flat rate for all additional amounts. Other companies issue special policies at lower rates but require a high minimum amount of insurance. Still other companies have a rate structure which charges less and less for each additional \$1,000 of insurance up to a given maximum. When premiums are not graded by amounts of insurance, it is necessary to determine the average amount written per policy and to load the premium accordingly. For example, if a given fixed cost per policy is \$6.30 and the average amount of insurance per policy is \$9,000, then a loading of 70 cents per policy would be sufficient to meet this cost. Purchasers of smaller policies will be paying less than their share, whereas purchasers of larger policies will be paying more than their share.

In loading systems the same percentage of premium or the same percentage of the policy amount cannot be used for all ages and still achieve the degree of equity desired without making suitable adjustments through the dividend formulas.³⁴ For example, based on 1958 CSO at 2½ per cent, the

³³ A recent development is to separate policies of large amounts and to reduce the loading percentage on them.

³⁴ Generally, comparatively simple formulas are used in setting the loading on participating policies since the dividend scale is relied upon to produce the necessary equity. Some thinking, however, is being given in actuarial circles to the desirability of making the loading on participating policies more equitable to relieve the burden on the dividend scale.

net level premium for \$1,000 continuous-premium whole life insurance issued at age 20 is \$10 75. At age 50 it is \$32 38. A 25 per cent loading based on premiums would produce about \$2.69 in one case, and about \$8.09 in the other. Since some of the expenses do not vary with the size of the premium, if \$2.69 is adequate for the policy issued at age 20, then \$8 09 must be excessive for the policy issued at age 50. A loading of \$5 00 per \$1,000 of insurance would produce an excessive amount at age 20 if it is adequate for age 60.

The same percentages also cannot be used for all plans and achieve the desired degree of equity. At age 20 the net level premium for a twenty-payment whole life policy figured on the basis of 1958 CSO at $2\frac{1}{2}$ per cent is \$19.48 per \$1,000. A loading of 24 per cent of this would produce \$4.87 compared to \$2.69 for the continuous-premium whole life policy. If the \$2.69 is adequate, then the \$4.87 would be excessive because the expenses of these two policies do not bear the same relationship to their premiums. A "modified percentage" plan of loading has been developed to solve this problem. A common plan is to load the continuous-premium whole life with 25 per cent of its net premium but to load the limited-payment whole life policy with $12\frac{1}{2}$ per cent of its net premium plus $12\frac{1}{2}$ per cent of the net premium for a continuous-premium whole life policy issued at the same age.³⁵

A flat amount per \$1,000 of insurance may be used along with the "modified percentage" loading plan to help achieve some semblance of equity between the loading at different ages of issue. A combination of both a fixed percentage of the premium and a flat amount per \$1,000 would to some extent counteract the bias inherent in each method.³⁶ Thus, the above percentages could be reduced and a flat amount of several dollars per \$1,000 of insurance could be added.

Term insurance presents a special loading problem. An additional loading is usually charged to take care of the initially adverse selection, and to cover the costs of any renewal and conversion privileges.

As may be expected, the system of loading used by any one company will usually vary from that of other companies,³⁷ and even the system of loading

³⁵ The endowment may be loaded with $6\frac{1}{4}$ per cent of its net premium, $6\frac{1}{4}$ per cent of the net premium for a limited-payment life issued at the same age for the same premium payment period, and $12\frac{1}{2}$ per cent of the premium for the continuous-premium whole life issued at the same age.

³⁶ If the aggregate loading is to be adequate, then one based on a given percentage of premium would yield an excessive amount at the high issue ages and an inadequate amount at the low issue ages. Conversely, one based on a flat amount per \$1,000 would yield an excessive amount at the low issue ages and an inadequate amount at the high ages of issue. These observations already have been demonstrated.

³⁷ Even though techniques among companies vary, results obtained are nearly the same. In participating companies there might be one significant difference. Some companies may load their premiums excessively to produce a surplus for high policy dividends, whereas others will prefer to keep their premiums low even if this means their dividends will not appear competitive. These latter companies prefer to make their premiums more attractive than their dividends.

used by any given company for the calculation of present rates may not be the same as was used to calculate rates in the past, nor the same as may be used to calculate rates in the future.

Nonparticipating Policies. A difference between the problems involved in determining the loading for participating policies and those involved in calculating the loading for nonparticipating policies is apparent. In the case of the latter, the company must attempt to figure the expenses more accurately and equitably because there is no way to make adjustments later. However, in the case of participating policies, unless inequities and inadequacies in loading are far more serious than even mediocre actuarial ability might produce, these inequities and inadequacies can be adjusted by varying the dividend scale.

The gross premium for nonparticipating policies must be sufficient to pay claims and expenses, to build contingency reserves, and to provide a profit, but it must be low enough to allow the company to compete successfully in the market place. This means that the actuary must walk the straight and narrow in his projections of mortality, interest, and expense rates.

In participating insurance, companies frequently use the same mortality and interest assumptions in computing their net premiums as they use in computing their legal reserves. Since these assumptions generally are ultra-conservative, they produce a redundant premium. To this redundant premium is added a not too carefully refined loading factor made up of a percentage of the net premium and perhaps a constant amount per \$1,000. The resulting redundancies and inequities are adjusted in the dividend formula.³⁸

For nonparticipating insurance, more realistic assumptions are necessary for premium computations than are prescribed for minimum reserves.³⁹ In fixing these assumptions the actuary either can use what he considers the most likely experience and then add a profit factor or he can use slightly more conservative assumptions (but less conservative than those used in participating insurance) and let the profit arise from achieving better than projected results.

The actuary, in selecting his mortality assumptions, may use the data compiled by the Society of Actuaries or that of his own company (if his company is large enough to produce credible experience). Of course, he can use some combination of the two. Select, rather than ultimate, tables are used by some actuaries, since they more nearly reflect actual experiences. With death rates declining, mortality tables based on current experience will become obsolete before the expiration of many of the policies that were priced on the basis of these tables. This suggests that a projection scale to adjust for expected mortality improvements would be necessary to achieve rate equity between new and old policies. Projection scales, however, are not

³⁸ Dividend formulas are discussed in Chapter 23.

³⁹ It is because of this fact that the problem of deficiency reserves (discussed in footnote No. 17) arose.

used in life insurance rating but are used by some companies in annuity rating.⁴⁰

What is a realistic interest assumption for the future? This is, in fact, an impossible question. One would have to be psychic to predict accurately the course of future interest rates over the duration of a life insurance policy. In the past twenty-five years, net interest earnings of life insurance companies have fluctuated from a high of 5.05 per cent to a low of 2.88 per cent. Currently, companies are earning more than 3½ per cent after taxes. But since aggregate results are significantly affected by small changes in the interest rate,⁴¹ the actuary is forced to answer the above question. In doing so, he tends to be conservative, but not as conservative for nonparticipating as for participating insurance. Common, but not universal, assumptions are 3 per cent for nonparticipating insurance and 2½ per cent for participating insurance. These assumptions seem overly conservative today. Tomorrow they might not seem so conservative.

Estimating future expenses connected with a policy is not an easy problem, either. Premium tax rates can be changed by state legislatures; alterations can be made in the federal income tax provisions and rates;⁴² and changes in the general price level can affect the cost of general overhead expenses.

After the actuary has decided on his mortality, interest, and expense assumptions, the task of computing the gross premium becomes one of applying a formula.⁴³ Under the formula the nonparticipating gross single premium⁴⁴ is the sum of the present value of projected future claims and the present value of expenses to be incurred, both figured at the policy issue date. How to compute these values and how to translate them into level premiums are the subject of Chapter 21.

Expense Ratios. Often an attempt is made, especially in competitive selling, to use comparisons between the expense ratios of different companies to indicate economy of operation. The expense ratio is essentially a relationship between operating expenses and premiums. Comparisons imply that if the

⁴⁰ Improvements in mortality among annuitants can cut heavily into the profits of the company.

⁴¹ Long-run results are more sensitive to a miscalculation of interest rates than to an equal miscalculation of mortality rates because, as a policy continues in force, its investment factor becomes increasingly more important and its mortality factor increasingly less important.

⁴² Allowance for federal income taxes usually is made in the interest assumptions rather than in the expense loading, the interest assumptions being net after taxes.

⁴³ Some formulas allow for an additional factor: withdrawal rates. Expenses are higher in the first year than in any other year. The expense loading, however, is spread on a level basis over the entire premium paying period. If a policyholder terminates his policy, the expenses incurred by that policy may have exceeded the amount of expense money collected to offset them. Only through the continuation of the policy and the payment of its premium will the company recover its high first-year expenses. The withdrawal rate is an allowance to offset the loss occasioned by early withdrawal. Many companies handle the withdrawal problem through their nonforfeiture valuation formula. Nonforfeiture valuation is discussed in Chapter 23.

⁴⁴ The full premium including the loading.

ratio of actual expenses to total premiums is low, economy of operation is indicated.

Such comparisons are invalid because they may contain figures arrived at on such differing bases as to render them useless for the purpose of comparing operating economy. Moreover, since acquisition costs are such a large part of loading, the company writing a large amount of new business—generally a desirable development, since the operation of the insurance principle depends upon the constant addition of new exposure units—will tend to show a higher percentage of incurred expenses to total premiums than will the company not writing a large volume of new business.

Expense ratios indicate the degree of accuracy with which the company has estimated its expenses, not the economy of operation. For example, if two companies had the same expenses and one used a higher estimate for loading, that company would have a lower expense ratio, assuming all other elements in the rate calculation were the same.

Actually, the cost of company operation and hence the size of the total loading factor in any gross premium is held about as low as is humanly possible—and “humanly” is intended in the literal sense, for there are extravagances or waste somewhere in the operation of every company. They occur because human beings are not perfect, and they appear in varying degree in any large organization—insurance or otherwise—regardless of careful, capable, and sincere management.

4. SUMMARY.

Three tools are needed to compute rates for life insurance—mortality, interest, and expense.

The purpose of mortality tables is to assist in predicting future claims. These tables can be computed from any one of three different sets of data: (1) The number living at each age from an original group; (2) the number dying at each age from an original group; and (3) the number dying each year out of the number living at the beginning of the year. After actual mortality rates are computed, a safety factor is added to allow a margin for contingencies. Mortality tables may be based on general population statistics, insured lives, or annuitants. They also may be classified into select, ultimate, and aggregate. The table commonly used today is the 1941 Commissioners' Standard Ordinary, which is an ultimate table. The 1958 CSO Table, also an ultimate table, is the newest table and the National Association of Insurance Commissioners has recommended its adoption as a minimum standard for reserve valuation by 1966 and that it be accepted on a voluntary basis until then.

Interest assumptions are important in rate-making because companies collect funds in advance of obligations. These funds are kept invested and the earnings on them must be considered in fixing the premiums.

Two types of premiums are gross and net. The gross premium is the net

premium plus loading. Loading covers four general items: (1) acquisition costs, (2) general overhead costs, (3) contingency funds, and (4) the cost of paying death claims immediately. Some of the expenses vary with the amount of the premium. Others vary with the amount of the insurance. Still others are constant, and depend only upon the number of policies issued. Loading systems differ among companies

Gross premiums on participating policies need not be so carefully computed as gross premiums on nonparticipating policies as long as they are adequate. Inequities and redundancies can be handled in the dividend formula.

QUESTIONS FOR CLASS DISCUSSION

1. Construct a mortality table from ages 35 to 39 using the following basic data.

<i>Age</i>	<i>Number of Living</i>	<i>Number Dying</i>
35	40,000	143
36	35,000	129
37	85,000	390
38	73,000	350
39	64,000	395

2. A mortality table has been described as the picture of "a generation of individuals passing through time." Comment on the accuracy of this description.
3. Explain why life insurance rates are not computed upon the basis of life expectancy
4. Explain why mortality tables used in annuity computations are different from those used in life insurance calculations
5. Explain how interest rates enter into life insurance premium calculations.
6. "Loading is more of a problem in cost accounting than of actuarial science." Explain why you agree or disagree with this statement.
7. If rate-making is a science, how do you account for the fact that all companies do not charge the same rates?
8. What effect will each of the following have upon the premium of a life insurance policy: (a) a shift from the 1941 CSO to the 1958 CSO Mortality Table; (b) a shift from a $2\frac{1}{2}$ per cent to a 3 per cent interest assumption. Why?
9. Explain why the problem of computing a gross premium for a nonparticipating policy is much more difficult than the problem of computing a gross premium for a participating policy.
10. Expense ratios differ among companies. How can these differences be explained?

CHAPTER 21

Computation of Premiums

Although the vast majority of life insurance policies are purchased on a level-premium basis, computation of a premium rate begins with the computation of the net single premium. The net annual level premium is then figured from the net single premium. The two must be mathematically equivalent.

This chapter will first summarize the steps required in calculating the net single premium and the application of these steps to the computation of rates for the three basic forms of life insurance policies and for annuities. Then it will consider the problem of translating single premiums to level premiums. Finally, premiums for health insurance will be discussed.

The computation of life insurance premiums in the body of this chapter is limited to arithmetic. An appendix is added to the chapter to discuss premium computation algebraically.

1. NET SINGLE PREMIUMS.

Two assumptions are made in the computation of annual premium rates for life insurance: (1) premiums are paid at the beginning of the year; (2) claims are paid at the end of the year.¹

The first assumption is accurate because the first premium must be paid before the policy goes into force; and unless each of the following premiums is paid when due (or within the grace period), the policy will not continue as originally written, but instead will be placed on one of the nonforfeiture options. Premiums paid more frequently than annually require special treatment.

The assumption that claims will be paid at the end of the year, however, is not true to fact. Actually, insurance companies pay their claims promptly upon completion of necessary forms. They realize that death creates costs that must be paid before the end of the policy year, and that widows and children do not wish to fast for the sake of simplifying actuarial compu-

¹ A third assumption must be made for premiums paid more frequently than annually if, as is the usual case, the balance of the annual premium is not required should death occur after the payment of one monthly or quarterly premium. This assumption is that the monthly deaths will be $\frac{1}{12}$ of the projected annual deaths. This, however, is not true to fact because death rates rise with age on a continuous basis. They increase monthly as well as yearly.

tations. Despite this payment practice, the assumption is used to simplify calculations. How the actuary compensates for this assumption already has been discussed.

The net single premium for any life insurance policy is the equivalent of the present value of the projected future claims under the policy based on given interest and mortality assumptions. For example, if 1,000 people of a given age are insured for \$1,000 for a period of five years and the projected deaths are ten in the first year, eleven in the second, twelve in the third, thirteen in the fourth, and fourteen in the fifth, a fund of \$55,520 at the beginning of the period (assuming a $2\frac{1}{2}$ per cent interest return) will be just enough to meet all claims projected during the term of the agreement. The cost for each of the 1,000 participants will be \$55.52 per policy ($\$55,520 \div 1,000$).

Here is how it works. The \$55,520 collected in advance will earn \$1,388 during the first year.² At the end of the year a total of \$10,000 will be paid in death claims, leaving \$46,908 to be invested throughout the second year. This earns \$1,173. After paying \$11,000 in claims, \$37,081 is available for investment the third year, and earns \$927. Claim payments of \$12,000 at the end of that year leave \$26,008 to earn \$650 interest during the fourth year. After subtracting \$13,000 for claims, \$13,658 is available to earn interest during the fifth year. This fund, invested at $2\frac{1}{2}$ per cent, will amount to \$14,000 at the end of the year, which is the exact amount needed to pay projected claims at that time.

The question now is how this figure of \$55.52 was computed? In Chapter 20 the use of mortality tables and interest assumptions in rate-making was described. The application of these tables and interest assumptions to specific problems can now be reviewed. The mortality assumptions to be used in the following pages are those contained in the 1958 CSO Table. Remember that in actual practice, however, companies may use mortality assumptions that are more in line with their own experience. Nevertheless, the use of the 1958 CSO assumption here does serve to illustrate the principle involved. The interest assumption used in this chapter is $2\frac{1}{2}$ per cent. Here again, companies vary as to their interest assumptions, but again the assumption used here is sufficient to illustrate the principle involved.

Steps in Calculating the Net Single Premium. To calculate a net single premium, the actuary needs to know (1) the plan of insurance, (2) the mortality table to be used, and (3) the rate of interest to be used.³ With this information, eight steps are involved in computing a net single premium.

Step 1. Determine what constitutes a claim: Two types of contingencies can be covered: the contingency of survival and the contingency of death. The

² Remember the assumption that premiums are paid in advance and claims are paid at the end of the year.

³ He would also need to know if death benefits are assumed to be payable at the end of the year of death or at the date of death. As previously mentioned, this discussion assumes that the benefits are payable at the end of the year of death.

annuity is an example of coverage for the contingency of survival, for it pays only as long as the insured lives.⁴ Term insurance is an example of coverage for the contingency of death, for it pays only if the insured dies during the term of years insured. The endowment policy is an example of a combination of both survival and death claims.

Step 2. Determine when claims are paid: Claims may be paid at the beginning of the year, at the end of the year, or any time during the year. For example, under an ordinary annuity, claims are paid at the end of the year; under an annuity due, claims are paid at the beginning of the year. Under life insurance policies, claims are paid as incurred, but the assumption is made that they are paid at the end of the year.⁵

Step 3. Find (from "number living" column of the mortality table) the number living at the issue age: In computing the premium, it is assumed that the number insured is the number living as shown on the mortality table for the age at which the policy is issued.

Step 4. Determine the probable number of claims per year, and multiply the figure for each year by \$1,000: If the number insured is assumed to be the number living at the age of entry, then the number of *death claims* each year must be taken from the deaths per year column for that year in the mortality table and for each succeeding year within the policy period. The number of *living claims* (if the policy covers that contingency) will be the figure in the number living column of the mortality table for the year or years involved.

Step 5. Determine the years of interest involved, and find the present value factor applicable for each of these years: The calculation here depends on the time at which claims are to be paid. If they are to be paid at the end of the year, then the funds for the first-year claims will earn one year's interest; those for the second year will earn two years' interest, etc. If claims are to be paid at the beginning of the year, funds for first-year claims will earn no interest; for the second year's claims, one year's interest; and so on. The present value factors can be ascertained from a present value table for the interest rate assumed.

Step 6. Calculate the present value of claim payments for each year during the period of coverage: Multiply the value of the claims for each year by the present value factor for that year. For instance, the value of the claims at the end of the first year will be multiplied by the present value factor for one year; funds for the second-year claims will be multiplied by the present value factor for two years, etc.

Step 7. Calculate the present value of all future claims: The computation here is merely the sum of the present values of claims for each of the years insured, as computed in step 6.

⁴ The fact that some annuities have a cash or installment value after death does not alter this statement, as will become apparent in the calculation of an annuity rate.

⁵ Some actuaries compute premiums on the basis that claims are paid as incurred. This calls for the assumption that deaths, on the average, occur in the middle of the year, and that claims are paid six months before the end of the year.

Step 8. Calculate the net single premium: The net single premium is the present value of all future claims divided by the number living at the age of entry.

How each of these eight steps is involved in calculating the net single premium for term, whole life, endowment, and annuity policies can now be illustrated.

The Net Single Premium for Term Insurance. The net single premium for a \$1,000 five-year term policy issued at age 25 is calculated as follows:

- (1) What constitutes a claim? Death.
- (2) When are claims to be paid? Although they are paid during the year, they are assumed to be paid at the end of the year.
- (3) How many are living at issue age? 9,575,636 (number living at age 25).
- (4) What is the amount of claims per year?

Age (a)	Number of Claims (b)	Amount of Insurance (c)	Amount of Claims (b × c)
25	18,481	\$1,000	18,481,000
26	18,732	1,000	18,732,000
27	18,981	1,000	18,981,000
28	19,324	1,000	19,324,000
29	19,760	1,000	19,760,000

(5) How many years of interest are involved? Since the assumption is that claims are paid at the *end* of the year, the following are the number of years of interest: age 25, one year; age 26, two years; age 27, three years; age 28, four years; age 29, five years.

The present value factors for each of the number of years involved are: one year, .97561; two years, .95181; three years, .92860; four years, .90595; five years, .88385.

- (6) What is the present value of the claims for each year?

Age (a)	Amount of Claims (b)	Years of Interest (c)	Present Value of \$1 (d)	Present Value of Claims (b × d)
25	18,481,000	1	.97561	18,030,248
26	18,732,000	2	.95181	17,829,305
27	18,981,000	3	.92860	17,625,757
28	19,324,000	4	.90595	17,506,578
29	19,760,000	5	.88385	17,464,876

- (7) What is the present value of *all* future claims? \$88,456,764.

(8) What is the net single premium of a five-year term issued at age 25?
 $\$88,456,764 \div 9,575,636 = \9.24 .

Whole Life Policies. A whole life policy is essentially a term policy which covers for the life of the insured rather than for a limited period. To abbreviate the illustration, the net single premium for a \$1,000 whole life policy issued at age 92 will be calculated.

- (1) What constitutes a claim? Death.

(2) When are claims paid? Although they are paid during the year, they are assumed to be paid at the end of the year.

(3) How many are living at issue age? 272,552 (number living at age 92).

(4) What is the amount of claims per year?

Age (a)	Number of Claims (b)	Amount of Insurance (c)	Amount of Claims (b × c)
92	72,480	\$1,000	\$72,480,000
93	57,881	1,000	57,881,000
94	45,026	1,000	45,026,000
95	34,128	1,000	34,128,000
96	25,250	1,000	25,250,000
97	18,456	1,000	18,456,000
98	12,916	1,000	12,916,000
99	6,415	1,000	6,415,000

(5) How many years of interest are involved? The years of interest are shown in Step No. 6 for ages 92 through 99, the year when all members of the group are assumed to be dead.

(6) What is the present value of claims per year?

Age (p × q)	Amount of Claims (p)	Years of Interest (r)	Present Value (q)	Present Value of Claims (v)
92	72,480,000	1	97561	70,712,213
93	57,881,000	2	95181	55,091,715
94	45,026,000	3	92860	41,811,144
95	34,128,000	4	90595	30,918,262
96	25,250,000	5	88385	22,317,213
97	18,456,000	6	86230	15,914,609
98	12,916,000	7	84127	10,865,843
99	6,415,000	8	82075	5,265,111
100				

(7) What is the present value of *all* future claims? \$10,272,000.

(8) What is the net single premium for a whole life policy issued at age 92? $\$252,896,110 \div 272,552 = \927.88 .

A more realistic whole life policy would be one issued at age 25 rather than at age 92. So that this figure will be available for use in computing a net level premium, the following is an abbreviated table showing the calculations of a net single premium for a whole life issued at age 25.

Age	Amount of Claims	Years of Interest	Present Value of \$1	Present Value of Claims
25	18,481,000	1	.97561	18,030,248
26	18,732,000	2	.95181	17,829,305
27	18,981,000	3	.92860	17,625,757
28	19,324,000	4	.90595	17,506,578
29	19,760,000	5	.88385	17,464,876

<i>Age</i>	<i>Amount of Claims</i>	<i>Years of Interest</i>	<i>Present Value of \$1</i>	<i>Present Value of Claims</i>
95	34,128,000	71	.17322	5,911,652
96	25,250,000	72	.16900	4,267,250
97	18,456,000	73	.16487	3,042,841
98	12,916,000	74	.16085	2,077,539
99	6,415,000	75	.15693	1,006,706

Here the present value of future claims would be \$325,236,476,740, which, divided by 9,575,636 equals \$339.65, the net single premium for a whole life issued at age 25.

Endowment Policies. The net single premium for a \$1,000 endowment at 65 issued at age 55 is computed as follows:

(1) What constitutes a claim? Claims are paid to those dying before age 65 and to those living at age 65.

(2) When are claims paid? Although the death claims are paid during the year, they are assumed to be paid at the end of the year. The living claims are paid at the end of the endowment period.⁶

(3) How many are living at issue age? 754,191 (number living at age 55).

(4) What is the amount of claims per year?

<i>Age</i>	<i>Number of Claims</i>	<i>Amount of Insurance</i>	<i>Amount of Claims</i>
55	108,307	\$1,000	\$108,307,000
56	116,849	1,000	116,849,000
57	125,970	1,000	125,970,000
58	135,663	1,000	135,663,000
59	145,830	1,000	145,830,000
60	156,592	1,000	156,592,000
61	167,736	1,000	167,736,000
62	179,271	1,000	179,271,000
63	191,174	1,000	191,174,000
64	203,394	1,000	203,394,000
65	6,800,531	1,000	6,800,531,000

(5) How many years of interest are involved? The years of interest are as shown in Step No. 6; since the *living* claims at age 65 are paid at the *beginning* of the year, there will be no interest earned during that year. Therefore, the same present value factor is used for the death claims paid at the end of age 64 and the living claims paid at the beginning of age 65.

(6) What is the present value of the claims for each year?

<i>Age</i>	<i>Amount of Claims</i>	<i>Years of Interest</i>	<i>Present Value of \$1</i>	<i>Present Value of Claims</i>
(a)	(b)	(c)	(d)	(b × d)
55	\$108,307,000	1	.97561	\$105,665,392
56	116,849,000	2	.95181	111,218,047

⁶ Under endowment at age 65 policies, the endowment benefit generally is payable to those who are living on the anniversary of the policy on which the insured's age, at nearest birthday, is 65. If the policy is a twenty-year endowment, for example, the living claims are paid to those living at the end of twenty years (the beginning of the twenty-first year).

Age (a)	Amount of Claims (b)	Years of Interest (c)	Present Value of \$1 (d)	Present Value of Claims (b × d)
57	125,970,000	3	.92860	116,975,742
58	135,663,000	4	.90595	122,903,895
59	145,830,000	5	.88385	128,891,846
60	156,592,000	6	.86230	135,029,282
61	167,736,000	7	.84127	141,111,265
62	179,271,000	8	.82075	147,136,673
63	191,174,000	9	.80073	153,078,757
64	203,394,000	10	.78120	158,891,393
65	6,800,531,000	10	.78120	5,312,574,817

(7) What is the present value of all future claims? \$6,633,477,109.

(8) What is the net single premium for an endowment at age 65, issued at age 55? $\$6,633,477,109 \div 8,331,317 = \796.21 .

Life Annuity Certain. The net single premium for a \$1,000 life annuity, five years certain, issued at age 90,⁷ is computed as follows:⁸

(1) What constitutes a claim? Claims are paid annually for five years dead or alive and thereafter for each year as long as the annuitant is alive at the end of the year.

(2) When are claims paid? At the end of the year.

(3) How many are living at issue age? 468,174.

(4) What is the amount of claims per year?⁹

Age	Number of Claims	Amount of Annuity	Amount of Claims
90	468,174	\$1,000	468,174,000
91	468,174	1,000	468,174,000
92	468,174	1,000	468,174,000
93	468,174	1,000	468,174,000
94	468,174	1,000	468,174,000
95	63,037	1,000	63,037,000
96	37,787	1,000	37,787,000
97	19,331	1,000	19,331,000
98	6,415	1,000	6,415,000

(5) How many years of interest are involved? Since claims are paid at the *end* of the year, the years of interest involved are those shown in tabular matter for Step No. 6.

(6) What is the present value of claims for each year?

Age	Amount of Claims	Years of Interest	Present Value of \$1	Present Value of Claims
90	\$468,174,000	1	.97561	456,755,236
91	468,174,000	2	.95181	445,612,695

⁷ This unrealistic age of issue is assumed for purposes of simplicity, i.e., to reduce the number of calculations involved.

⁸ The 1958 CSO Table will be used in this and other annuity illustrations, although more realistic results would be obtained by using an annuity mortality table. Nevertheless, the principle is the same regardless of the table used, and the principle is all that is of interest here.

⁹ The full number buying the policy (468,174) will be paid claims during the first five years; only those living thereafter will continue to be paid claims.

Age	Amount of Claims	Years of Interest	Present Value of \$1	Present Value of Claims
92	468,174,000	3	.92860	434,746,376
93	468,174,000	4	.90595	424,142,235
94	468,174,000	5	.88385	413,795,590
95	63,037,000	6	.86230	54,356,805
96	37,787,000	7	.84127	31,789,069
97	19,331,000	8	.82075	15,865,918
98	6,415,000	9	.80073	5,136.683

(7) What is the present value of *all* future claims? \$2,282,200,607.

(8) What is the net single premium for a life annuity, five years certain, issued at age 90? $\$2,282,200,607 \div 468,174 = \$4,874.68$.

Temporary Life Annuity Due. The net single premium for a five-year temporary life annuity due of *one dollar* issued at age 25 is computed as follows:

- (1) What constitutes a claim? Claims are paid annually to those alive.
- (2) When are claims paid? At the beginning of the year.
- (3) How many are living at issue age? 9,575,636.
- (4) What is the amount of claims per year?

Age	Number of Claims	Amount of Annuity	Amount of Claims
25	9,575,636	\$1	9,575,636
26	9,557,155	1	9,557,155
27	9,538,423	1	9,538,423
28	9,519,442	1	9,519,442
29	9,500,118	1	9,500,118

(5) How many years of interest are involved? Since claims are paid at the *beginning* of the year, the following are the years of interest: age 25, none; age 26, one year; age 27, two years; age 28, three years; age 29, four years.

- (6) What is the present value of claims for each year?

Age	Amount of Claims	Years of Interest	Present Value of \$1 at $2\frac{1}{2}\%$	Present Value of Payments
25	\$9,575,636	0	1.00000	
26	9,557,155	1	.97561	
27	9,538,423	2	.95181	
28	9,519,442	3	.92860	
29	9,500,118	4	.90595	

(7) What is the present value of all future claims? 45,422,844.

(8) What is the net single premium for a five-year temporary life annuity due issued at age 25? $\$45,422,844 \div 9,575,636 = \4.74 .

Whole Life Annuity Due. The net single premium for a whole life annuity due is computed in exactly the same manner as a temporary life annuity due, except that it is computed from issue age through age 99.

For example, the net single premium for a whole life annuity due issued at age 25 is computed as follows:

Age	Amount of Claims	Years of Interest	Present Value of \$1 at 2½%	Present Value of Payments
25	\$9,575,636	0	1.00000	\$9,575,636
26	9,557,155	1	.97561	9,324,056
27	9,538,423	2	.95181	9,076,766
28	9,519,442	3	.92860	8,839,754
29	9,500,118	4	.90595	8,606,632
95	97,165	70	.17755	17,252
96	63,037	71	.17322	10,919
97	37,787	72	.16900	6,386
98	19,331	73	.16487	3,187
99	6,415	74	.16085	1,032
				<u>\$259,212,467</u>

Here $\$259,212,467 \div 9,575,636 = \27.07 , present value of life annuity due.

As will become apparent in the next section, the present value of an annuity due of \$1.00 is a useful device for converting single premiums into level premiums.

2. NET LEVEL PREMIUMS.

Few people are able to purchase life insurance on a single-premium basis, and even fewer are willing to do so. They want to budget their insurance into a series of annual payments, either for life or for a limited number of years. Broadly speaking, two plans are available for the purchase of life insurance on an annual-premium basis: (1) yearly-renewable term insurance and (2) the level-premium plan.

Yearly-Renewable Term Plan. Under the yearly-renewable term plan, the insured pays a single premium for one year of insurance and has the right to renew the policy without proving insurability for additional one-year periods at the premium applicable for the age of renewal. The premium increases each year with the increase in the rate of mortality. The net premium (sometimes called the net natural premium) is the mortality cost in accordance with the mortality table used for each year, discounted for one year. Accordingly, the net premiums each year for a yearly-renewable term policy of \$1,000 issued at age 25 and renewable for five years, would be:

First year	$1.93 \times .97561 = 1.88$
Second year	$1.96 \times .97561 = 1.91$
Third year	$1.99 \times .97561 = 1.94$
Fourth year	$2.03 \times .97561 = 1.98$
Fifth year	$2.08 \times .97561 = 2.03$

If this were renewed for thirty years, the rate would rise to $\$11.90 \times .97561$, or \$11.61 per \$1,000, in the thirtieth year. The one-year discount factor is used in each of the above computations because, under the yearly-renewable term plan, only the cost of one-year term insurance is paid each year. Because

the premium is paid at the beginning of the year and claims are assumed to be paid at the end of the year, one year's discount is involved.

The vast majority of the insuring public not only does not like to pay for its insurance with a large single premium, but also it does not like premiums that increase each year. Thus, for a whole life policy, the majority would prefer a net annual level premium rather than a net single premium of \$339.65 or a net premium starting at \$1.88 and progressing to an almost prohibitive level. For example, the net yearly-renewable term premium at age 70 is nearly twenty-six times that at age 25.

Level Annual-Premium Plan. The level annual-premium plan is a method by which premiums are spread evenly on an annual basis over the duration of the policy or over a limited number of years.

A division of the net single premium by the number of years over which the premium is to be paid will not produce a sufficient net level annual premium.

A simple division of this type ignores the two important factors in rate-making, interest and mortality.

In computing the net single premium, it is assumed that the company collects the entire premium in advance and earns interest on it until the funds are used to pay claims, one, two, three, four, and five years hence. Under the level annual-premium plan, only part of the full net premium is collected in advance. Consequently, there will be a substantial loss in interest on the unpaid portion. Allowance must be made in level annual-premium computations to offset this loss.

The net single-premium computation also assumes that the full net single premium is paid by everyone. The level annual premium, however, is collected only from those who are alive on each succeeding premium due date. Under this plan, death cancels the obligation to pay further premiums. The level annual premium, therefore, must compensate for the possible cancellation of premium obligations.

How can an allowance for the loss of interest and premiums be computed? Actually, a level premium is an annuity payable to the company by the policyholder. The premium payments for a twenty-year term or for a twenty-year life represent a temporary life annuity for twenty years, whereas the level premium for a continuous-premium whole life policy is a whole life annuity payable by the policyholder to the company.

Use of the Annuity Due in Computing the Net Level Annual Premium. Since premiums are paid at the beginning of the year¹⁰ the net level premium

¹⁰ Level premiums are almost universally computed on an annual basis; i.e., the premium is the amount due at the beginning of each policy year. Premiums payable at more frequent intervals are called fractional premiums and are installments of the annual premium. Any unpaid installments at the time of the death of an insured were once almost universally deducted from the claim. For instance, if an insured who paid his premiums quarterly died in the first quarter, the three unpaid installments were due and were deducted from the policy proceeds. The current practice among many companies,

is an annuity due. (It will be remembered that an annuity due is one under which "benefits" are paid at the beginning of the period rather than at the end of the period, as in an ordinary annuity. And, since the payments are not guaranteed but are contingent on the continued life of the annuitant, the annuity due is a life annuity due.)

Previously, the net single premium for a temporary life annuity due of \$1.00 for five years issued at age 25 was found to be \$4.74. Thus, a single payment of \$4.74 at the age of 25 is the mathematical equivalent of an annual payment of \$1.00 at the beginning of each of the five years from ages 25 to 29 inclusive, on behalf of those who survive each year.¹¹ Consequently, if the net single premium for a five-year policy issued at age 25 (1958 CSO, 2½ per cent) is \$4.74, it follows that the net level annual premium would be \$1.00. If the net single premium were \$500, the annual premium would be $500 \div 4.74$ or 105.49.¹²

To find the net level annual premium for any policy, the net single premium is divided by the present value of an annual annuity due of one for the premium-paying period. It should be stressed that the annuity due is FOR the term of years over which premiums are to be paid. This may or may not be the same as the term of the policy. For instance, a whole life policy may call for continuous premiums or the premium period may be limited. If it is a continuous-premium policy, then the present value of a whole life annuity due is used. If it is a twenty-pay policy, the present value of a temporary life annuity due for twenty years is used.

Steps in Calculating of the Net Level Annual Premium. The following are the steps in calculating a net level premium:

- (1) Determine the net single premium for the policy.
- (2) Determine the present value of an annual life annuity due for the premium-paying period.
- (3) Determine the net level annual premium by dividing Step No. 1 by Step No. 2.

To illustrate the steps, the net level premium for a limited payment and for a continuous-payment policy are computed as follows:

Limited-Payment Life Policies. What would be the net level premium for a five-pay whole life policy issued at age 25?

- (1) What is the net single premium for the policy? This was calculated previously and found to be \$339.65.

however, is to collect premiums only until the end of the month in which death occurs, refunding any part of the premium paid beyond that time. The loss of the fractional premiums is absorbed in the rate margins

¹¹ If no allowance were made for interest and mortality, the present value would be the sum of the annual payments—in the above case \$5 00 instead of \$4 74. The 26-cent margin is the allowance for interest and premium loss per \$1,000 of level annual premium in this illustration.

¹² The equation is $500.x = 4.74:1.00$. The formula for solving this equation is the means times the extremes. Thus, $4.74x = 500$, or $x = 500 \div 4.74$.

(2) What is the present value of a five-year temporary life annuity due of one per annum? This was calculated previously and found to be \$4.74.

(3) Determine the net level annual premium. $\$339.65 \div 4.74 = \71.66 .

Continuous-Premium Whole Life. What would be the net level annual premium for a continuous-payment whole life policy issued at age 25?

(1) What is the net single premium for the policy? This was computed previously and found to be \$339.65.

(2) What is the present value of a whole life annuity due? This was calculated previously and found to be \$27.07.

(3) Determine the net level annual premium: $\$339.65 \div 27.07 = \12.55 .

Endowment, Term, and Annuities. The procedure for calculating the net level annual premium for other than whole life policies presents no new problems. To find the net level annual premium, the net single premium for any policy is divided by the present value of an annual life annuity due for the premium-paying period. In the case of a ten-year term policy the life annuity due would be for ten years; in the case of a twenty-year endowment, the life annuity due would be for twenty years. In the case of a pure deferred annuity at 65 paid for on an annual-premium basis from, say, age 35, the life annuity due would be for thirty years.

Special Policy Combinations. Rate calculation for the many special policy combinations that will be found, such as family income, family maintenance, double protection, and retirement income, are based on the same principles as term, whole life, and endowment. To compute the net level annual premium for any of them, all that is necessary is to find the present value of all projected future claims per policy (net single premium) and divide this by the present value of a life annuity due of one per annum for the premium-paying period.

The net single premium on a double protection policy, for instance, is the present value of the projected claims under the term and under the whole life portions of the policy. The net level annual premium can then be computed by using the appropriate life annuity due for the premium-paying period. In some cases the premium-paying period for the entire policy will be for the whole of life, whereas in other cases the premium-paying period might be divided, one part for the whole of life and another part for the period during which the term protection is offered.

3. HEALTH INSURANCE PREMIUMS.

Basically, the calculation of a premium rate for health insurance coverage is the same as that for life insurance. A "pure" or net rate is determined, to which is added a margin for expenses and contingencies.

The specialized underwriting problems and unique characteristics of health insurance introduce certain actuarial problems in rate-making for this

form of insurance that are not found in life insurance. For instance, it is considerably more difficult to define "disability" on a basis that will lead to objective treatment of claims than it is to define "death." Also, claim frequencies and average claim values under health insurance do not have the same stability as the rate of mortality, but tend to vary from time to time, partly as a result of variations in the economic cycle.¹³ Health insurance rates are based on more judgment and less statistics than are life insurance rates.

The gross rate paid by the policyholder is made up of the pure insurance premium (net rate) plus loading for expenses, taxes, a margin for contingencies, and a margin for profit or policy dividends. The first step in calculating the gross rate is, then, calculation of the pure rate.

Pure or Net Rate. The percentage of claims occurring during a year among a given number of policyholders is the "claim rate."¹⁴ The pure insurance premium is obtained by multiplying the claim rate by the average value of the claims. In the case of insurance coverage for which the benefit has a fixed amount, such as a death or dismemberment benefit, the average value of claims is, of course, the amount of the benefit. The benefits for certain coverages, however, are not fixed but are variable and depend on a period of disability or an amount of medical expense incurred. For example, in the case of loss-of-time coverage for \$100 per month, the average benefit per claim will be the present value of \$100 per month payable during disability.

Average claim values are determined by statistical analysis. Available statistics for health insurance are limited. In 1926 and 1953 the Society of Actuaries published statistics based on life insurance disability riders. They also prepare statistics on double indemnity benefits, and provide statistics on a regular basis for group health insurance. The Bureau of Accident and Health Underwriters (now merged into the Health Insurance Association of America) published statistics on individual health insurance. As health insurance matures, better statistics undoubtedly will become available and rate-making will take on more of a scientific flavor than has been the case in the past or is the case at present.

Most rate-making starts with the calculation of the pure insurance rate for a term of one year. If the peril is accidental death, the pure insurance rate is the probability of accidental death at a given age, multiplied by the amount of insurance. For example, if the claim rate is one in 1,000 and the amount of insurance is \$1,000, then the pure insurance rate for a term of one year is \$1.00.

If the peril is loss of time from total disability, then the pure insurance

¹³ A period of economic depression will greatly increase claim frequency and claim value. The man who is unemployed has less incentive to get well. As long as he remains disabled, his income from insurance will continue. When he gets well, he will have no income.

¹⁴ Also called "claim frequency" and "probability of occurrence."

premium is the claim rate multiplied by the average benefit per claim. For example, if the claim rate at a given age is 200 in 1,000, and the average claim is \$250, the one-year, pure insurance rate is $.2 \times \$250$, or \$50.¹⁵

Level Premium. If claim rates and average claim values do not vary greatly over the years covered by the benefit offered, then a level premium can be achieved simply by using the pure premium at all ages. If the claim rate and average claim value do vary significantly, benefits can be reduced at older ages, rates can be jumped by age groupings, or a level premium can be calculated in the same way as one is calculated for life insurance: a single premium is developed equal to the present value of the one-year premiums for all ages covered and then divide by an annuity due payable to the age at expiry of coverage.

This is the method usually used in figuring rates for non-cancellable, guaranteed renewable policies.

Loading. The pure insurance rate must be loaded for acquisition costs, expenses, regular and contingency reserves, and profit or policy dividends.

The largest item of acquisition cost is agents' commissions. Two types of commission plans are used in health insurance: (1) *Level plan*: a relatively low (compared to life insurance) first-year commission of, say, 25 per cent, followed by the same commission rate on each subsequent annual renewal. (2) *Unlevel*: a relatively high first-year commission as in the case of life insurance, followed by relatively low renewal commissions—say, 40 per cent, plus 10 per cent renewals. The level plan will produce a greater loading factor if the business persists less than two years, whereas the unlevel plan will produce a higher loading factor if the average persistency of the business is more than two years. For instance, the 25 per cent level plan will cost 75 per cent of one year's premium for a persistency of three years, whereas the 40 per cent to ten per cent unlevel plan over the same period will cost only 60 per cent of one year's premium. On the other hand, if the policy persists only one year, the level plan will cost 25 per cent of one year's premium, whereas the unlevel plan will cost 40 per cent.

Making Up the Premium. Rates are usually calculated on a unit basis, say \$1,000 as the unit for accidental death and dismemberment benefits and \$100 per month as the unit for loss-of-time benefits. A unit for hospital expense is usually \$1.00 per day of benefit, whereas unit cost for surgical is based on the maximum benefit in the surgical schedule. The premium for any policy is the total of the unit rates involved.

Rating Factors. The rate for a health insurance policy is based on three factors: age, occupation, and sex. The occupational factor is more important for accident insurance than for sickness insurance, but premium rates and

¹⁵ This ignores any discount for interest, which can be ignored safely in a one-year term calculation unless the maximum period for which the indemnity is payable is lengthy.

other underwriting practices in connection with sickness insurance as well as accident insurance, generally depend upon the occupational factor.

The rate for commercial disability income insurance usually does not vary with age until age 55. Because of the increase in the morbidity rate at later ages, the rate after age 55 usually is higher. Hospital, surgical, and basic medical care plans have one rate for adults, and another for children. Again at later ages, a differential may be changed because of the higher morbidity rate. Guaranteed renewable disability income policies and major medical insurance are usually put on a level-premium plan and graded by age. Children, however, take a flat rate under major medical insurance.

Studies have shown that women experience a higher rate of disability than men. The cost of health insurance, therefore, is usually higher for women than for men. (Commonly, of course, disability income insurance is written on employed women only.)

Elimination Periods. It is common in disability income policies to provide for an "elimination" or "waiting" period for each disability—particularly for sickness coverage. Under such clauses, benefits do not begin until the end of the first few days or weeks (depending on the policy provision) of each period of disability. Thus, the company pays and charges only for the larger, more uncertain part of losses, which actually should be the only losses insured. As a result (1) the pure premium can be greatly reduced because a smaller amount is paid out in claims, and (2) loading can be reduced because the expenses of handling numerous small losses is eliminated.

4. SUMMARY.

The net single premium of a \$1,000 life insurance policy is equal to the present value of all projected claims under the policy. Claims are estimated from mortality tables and are discounted by use of compound interest tables. Both mortality and interest assumptions vary among companies.

As a rule, policyholders prefer to buy their insurance on the level-premium plan. To compute the level annual premium, it is necessary to divide the single premium by the present value of a life annuity due of one for the premium-paying period, since actually a level premium is an annuity payable by the policyholder to the company.

Rate computation for health insurance is much like that for life insurance. However, health insurance faces the problems of inadequate data and the subjective nature of the hazard.

QUESTIONS FOR CLASS DISCUSSION

1. Compute the net single premium for a five-year term policy issued at age 30. Explain each step in the computation.
2. Compute the net single premium for a five-year endowment issued at age 30.

3. Compute the net single premium for a five-year life annuity due at age 30
4. Compute the net level annual premium for a five-year term policy issued at age 30.
5. Compute the net level annual premium for a five-year endowment issued at age 30.
6. Explain why the net level premium for a five-year term policy is *not* the net single premium divided by five.
7. Explain any significant differences between rate-making in health insurance and that in life insurance
8. How would the net single premium be computed if the assumption were made that claims are paid when incurred rather than at the end of the year?
9. Compute the net single premium for a five-year 1 per cent family income rider
10. Compute the net level annual premium for a five-year 1 per cent family income rider.

A Mathematical Note

In the past few pages, premiums were computed arithmetically. Premiums, however, are actually computed algebraically. In order to understand the formulas used by the actuary in his work, the student must first learn a new language—the language of symbols or notations.

Mortality Symbols. The symbol for the number of persons living is (l). The age involved is represented by a figure placed beside the l . Thus, the number living at age 25 would be represented by l_{25} . The mortality table column indicating the number of people living at each age in the table is labeled l_x , x representing the age involved.

The number dying is indicated by the symbol (d). The age is shown by a small number opposite the symbol. Therefore, the number dying at age 21 is d_{21} . The death column in the mortality table is headed by d_x .

The rate of mortality is reflected by the symbol q_x , which indicates the proportion of lives aged x dying during the year. The rate of mortality per 1,000 column in the mortality table is labeled $1,000q_x$.

Thus, the following equations may be established:

$$(1) d_x = l_x - l_{x+1}^1$$

$$(2) q_x = \frac{d_x}{l_x}^2$$

One additional column usually found in the mortality table is expectation of life, the average number of years to be lived in the future by lives now aged x . The symbol (e_x) is used to express this figure and it is the label used for that column.³ Another symbol used with mortality tables is (w), the last year in the table at which l_x is larger than zero. On the 1958 CSO Table, this is age 99 since age 100 is the limiting age of the table.

Interest Symbols. In life insurance, actuaries are interested in present values, at compound interest, of sums due in the future. The symbol for the

¹ Assume age 25. The number dying at age 25 is 18,481 (1958 CSO). The number living at age 25 is 9,575,636. The number living at age 26 is 9,557,155. $18,481 = 9,575,636 - 9,557,155$.

² The rate of mortality at age 25 is $18,481 \div 9,575,636$ or .193 per cent or 1.93 per 1,000.

³ Two expectations of life figures are computed: curtate and complete. Curtate (reduced) includes only the full years involved, leaving out any fraction of a year, whereas complete expectation of life includes the fraction. The symbol for curtate expectation is (e_x); for complete (\bar{e}_x).

present value of 1 due in n years is (v^n) .⁴ Figured at $2\frac{1}{2}$ per cent, v^n equals .9756098⁵ where n is one year. Where n is two years, v^n is .9518144.⁶ Actuaries work with tables of v^n values.

Symbols for the Expression of Premiums. The following symbols are used to indicate premiums:

$A_{x:\overline{n}|}^1$ = The net single premium for n -year term.

A_x = The net single premium for whole life.

$A_{x:\overline{n}|}$ = The net single premium for n -year endowment.

a_x = The net single premium for whole life annuity.

$\ddot{a}_{x:\overline{n}|}$ = The net single premium (present value) for temporary life annuity due.

\ddot{a}_x = The net single premium (present value) for whole life annuity due.

P_x = Net annual level premium for continuous-premium whole life.

${}_nP_x$ = Net annual level premium for limited-payment whole life.

$P_{x:\overline{n}|}^1$ = Net annual level premium for n -year term.

$P_{x:\overline{n}|}$ = Net annual level premium for n -year endowment.

Formulas for Net Single Premiums. For an n -year term policy, the formula for the net single premium is:

$$A_{x:\overline{n}|}^1 = \frac{vd_x + v^2d_{x+1} + v^3d_{x+2} + v^4d_{x+3} + \cdots + v^nd_{x+n-1}}{l_x} \quad (1)$$

For a whole life policy, the net single premium formula is:

$$A_x = \frac{vd_x + v^2d_{x+1} + v^3d_{x+2} + v^4d_{x+3} + \cdots + v^{w-x+1}d_w}{l_x} \quad (2)$$

For an n -year endowment, the net single premium is:

$$A_{x:\overline{n}|} = \frac{vd_x + v^2d_{x+1} + v^3d_{x+2} + v^4d_{x+3} + \cdots + v^nd_{x+n-1} + v^nl_{x+n}}{l_x} \quad (3)$$

For a whole life annuity, the net single premium is:

$$a_x = \frac{vl_{x+1} + v^2l_{x+2} + v^3l_{x+3} + v^4l_{x+4} + \cdots + v^{w-x}l_w}{l_x} \quad (4)$$

⁴ The formula for computing present values is $P = A(1+i)^{-n}$ where P is the present value, A the amount, i the compound rate of interest, and n the number of years involved. The symbol (v) is $(1+i)^{-1}$. Thus $P = Av^n$. Where A is 1, P becomes v^n .

⁵ $P = 1(1+.025)^{-1}$ or $\frac{1}{1.025}$ or .9756098.

⁶ $P = 1(1+.025)^{-2}$ or $\frac{1}{(1.025)^2}$ or .9518144.

Commutation Symbols. Numerous computations would be necessary to work out the above formulas. To reduce the amount of arithmetic required, a set of commutation symbols have been created. The values of these symbols are presented in tabular form in what are called commutation columns. The columns are based on a given mortality table and a given interest assumption. Table 43 shows the commutation columns for the 1958 CSO at $2\frac{1}{2}$ per cent. The symbols shown in these columns are (D_x) , (N_x) , (C_x) , and (M_x) . Their meanings are as follows:

$$D_x = v^x l_x$$

$$N_x = D_x + D_{x+1} + D_{x+2} + D_{x+3} + \cdots + D_w$$

$$C_x = v^{x+1} d_x$$

$$M_x = C_x + C_{x+1} + C_{x+2} + C_{x+3} + \cdots + C_w$$

Here is how the commutation symbols are used to simplify the arithmetic of premium computations. Note that the denominator in formulas (1) through (4) is l_x . If the denominator and numerator in these formulas are multiplied by v^x , the denominator becomes $v^x l_x$, which, as indicated above, is represented by symbol (D_x) . The numerator in formulas (1) through (3) becomes $v^{x+1} d_x + v^{x+2} d_{x+1} + v^{x+3} d_{x+2}$ etc. Since the symbol (C_x) is used to indicate $v^{x+1} d_x$, the formula for the net single premium for an n -year term policy can be written as follows:

$$A^1_{x:n} = \frac{C_x + C_{x+1} + C_{x+2} + C_{x+3} + \cdots + C_{x+n-1}}{D_x} \quad (5)$$

The formulas for whole life and n -year endowments are written:

$$A_x = \frac{C_x + C_{x+1} + C_{x+2} + C_{x+3} + \cdots + C_w}{D_x} \quad (6)$$

TABLE 43.

1958 CSO Table
Commutation Columns-Interest at $2\frac{1}{2}$ %

Age	D_x	N_x	C_x	M_x
0	10000000.0000	324850104.9680	69073.1710	2076826.7172
1	9687024.4290	314850104.9680	16632.9566	2007753.5462
2	9434122.5838	305163080.5390	13990.2787	1991120.5896
3	9190031.7084	295728957.9552	13090.0808	1977130.3109
4	8952794.4741	286538926.2468	12228.1241	1964040.2301
5	8722205.5791	277586131.7727	11487.5189	1951812.1060
6	8497981.3556	268863926.1936	10778.2903	1940324.5871
7	8279935.2370	260365944.8380	10178.0782	1929546.2968
8	8067807.4636	252086009.6010	9681.6066	1919368.2186
9	7861350.0557	244018202.1374	9279.8558	1909686.6120

1958 CSO Table
Commutation Columns-Interest at 2½% (continued)

<i>Age</i>	<i>D_x</i>	<i>N_x</i>	<i>C_x</i>	<i>M_x</i>
10	7660329 9546	236156852 0817	9042 8478	1900406 7562
11	7464449 7860	228496522 1271	8957 6178	1891363 9084
12	7273432 4866	221032072 3411	8940 8062	1882406 2906
13	7087090 8833	213758639 8545	9126 8500	1873465 4844
14	6905108 1581	206671548 9712	9364 0939	1864338 6344
15	6727326 7826	199766440 8131	9582 3146	1854974 5405
16	6553663 2627	193039114 0305	9846 7536	1845392 2259
17	6383971 1254	186485450 7678	10090 0279	1835545 4723
18	6218174 4633	180101479 6424	10252 3993	1825455 4444
19	6056259 3006	173883305 1791	10280 6243	1815203 0451
20	5898264 9735	167827045 8785	10300 1828	1804922 4208
21	5744104.7377	161928780 9050	10255 1657	1794622 2380
22	5593749 4258	156184676 1673	10150 6810	1784367 0723
23	5447165.8414	150590926.7415	10044 0865	1774216 3913
24	5304263.9929	145143760 9001	9883 7932	1764172 3048
25	5165007.9517	139839496 9072	9725 3439	1754288 5116
26	5029306 7854	134674488 9555	9617 0037	1744563.1677
27	4897023 7928	129645182 1701	9507 1611	1734946 1640
28	4768076 9758	124748158 3773	9442 8900	1725439 0029
29	4642339 5370	119980081.4015	9420 4356	1715996 1129
30	4519691 3751	115337741 8645	9392.0634	1706575.6773
31	4400062 8465	110818050 4894	9401 2183	1697183 6139
32	4283343.0569	106417987 6429	9402 5686	1687782 3956
33	4169468 7479	102134644.5860	9437 1317	1678379 8270
34	4058337.1968	97965175 8381	9502 3390	1668942.6953
35	3949851 0856	93906838 6413	9672 2130	1659440 3563
36	3843840.9771	89956987 5557	9900.3401	1649768 1433
37	3740188 4751	86113146 5786	10217.2318	1639867 8032
38	3638747 0704	82372958.1035	10685 3232	1629650 5714
39	3539311 8617	78734211 0331	11222.0794	1618965.2482
40	3441765.0620	75194899.1714	11853 1042	1607743 1688
41	3345966.5023	71753134 1094	12535 2926	1595890.0646
42	3251822.2774	68407167.6071	13229 3739	1583354.7720
43	3159280.1784	65155345 3297	13962.4424	1570125.3981
44	3068262.0685	61996065.1513	14727 5918	1556162.9557
45	2978698.8164	58927803.0828	15547.3085	1541435 3639
46	2890500 3526	55949104.2664	16440 4699	1525888.0554
47	2803559 9048	53058603 9138	17395 7457	1509447 5855
48	2717784.6405	50255044.0090	18427.9447	1492051 8398
49	2633069 2135	47537259 3685	19523 3861	1473623.8951
50	2549324.6723	44904190 1550	20692 9455	1454100.5090
51	2466453.0891	42354865 4827	21921 2231	1433407.5635
52	2384374.4270	39888412 3936	23169 1325	1411486.3404
53	2303049.8123	37504037.9666	24468 5917	1388317.2079
54	2222409 2905	35200988.1543	25801 7117	1363848.6162

Age	D_r	N_r	C_r	M_r
55	2142402 4988	32978578 8638	27171 9031	1338046 9045
56	2062976 8254	30836176 3650	28599 9098	1310875 0014
57	1984060 3996	28773199 5396	30080 3536	1282275 0916
58	1905588 3725	26789139 1400	31604 8230	1252194 7380
59	1827505.7998	24883550 7675	33144 7659	1220589 9150
60	1749787 7198	23056044.9677	34722 7242	1187445 1491
61	1672387 2632	21306757 2479	36286 6291	1152722 4249
62	1595310 6622	19633869 9847	37836 1144	1116435 7958
63	1518564.5694	18038559 3225	39364 2006	1078599.6814
64	1442162 1578	16519994 7531	40858 9196	1039235 4808
65	1366128 5462	15077832.5953	42316 6940	998376.5612
66	1290491 6985	13711704 0491	43738 1310	956059 8672
67	1215278 1249	12421212 3506	45101 6207	912321 7362
68	1140535 6099	11205934 2257	46378 0358	867220 1155
69	1066339 5743	10065398 6158	47449 5963	820842.0797
70	992881 7500	8999059 0415	48229 7870	773392 4834
71	920435 3077	8006177 2915	48625 9779	725162 6964
72	849359 6946	7085741 9838	48599 8832	676536 7185
73	780043 7396	6236382 2892	48142 0663	627936 8353
74	712876 2140	5456338 5496	47376 6752	579794 7690
75	648112 3021	4743462 3356	46392 1628	532418 0938
76	585912 5111	4095350 0335	45261 0951	486025 9310
77	526360 8716	3509437 5224	44008 9628	440764 8359
78	469513 8465	2983076.6508	42627 3426	396755 8731
79	415434.9294	2513562 8043	41012 5834	354128 5305
80	364289 7989	2098127.8749	39087 3533	313115 9471
81	316317 3241	1733838.0760	36831 6174	274028 5938
82	271770 6619	1417520 7519	34248 4382	237196 9764
83	230893.6600	1145750 0900	31397.0289	202948 5382
84	193865 0736	914856.4300	28372 4430	171551 5093
85	160764 2229	720991.3564	25273.7507	143179.0663
86	131569 3974	560227.1335	22183.1949	117905 3156
87	106177 1855	428657 7361	19177.1362	95722 1207
88	84410 3641	322480 5506	16326.1748	76544 9845
89	66025.3978	238070 1865	13685.6613	60218.8097
90	50729.3636	172044 7887	11291 0955	46533 1484
91	38200.9638	121315 4251	9159 6932	35242 0529
92	28109.5415	83114 4613	7292 8738	26082 3597
93	20131.0686	55004 9198	5681 8884	18789 4859
94	13958.1795	34873.8512	4312 1729	13107.5975
95	9305 5630	20915.6717	3188 7449	8795.4246
96	5889.8533	11610 1087	2301.6880	5606.6797
97	3444 5103	5720 2554	1641 3408	3304 9917
98	1719 1569	2275.7451	1120 6380	1663 6509
99	556 5882	556 5882	543.0129	543.0129

$$A_{x:\overline{n}|} = \frac{C_x + C_{x+1} + C_{x+2} + C_{x+3} + \cdots + C_{x+n-1} + D_{x+n}}{D_x} \quad (7)$$

Since the symbol (M_x) is used to express $C_x + C_{x+1} + C_{x+2} + C_{x+3} + \cdots + C_w$, the formula for the net single premium for an n -year term policy can be further reduced to:

$$A^1_{x:\overline{n}|} = \frac{M_x - M_{x+n}}{D_x} \quad (8)$$

For whole life and n -year endowments, the formulas are:

$$A_x = \frac{M_x}{D_x} \quad (9)$$

$$A_{x:\overline{n}|} = \frac{M_x - M_{x+n} + D_{x+n}}{D_x} \quad (10)$$

For the net single premium for a whole life annuity, the numerator in formula (4) after multiplying by v^x becomes:

$$a_x = \frac{v^{x+1}l_{x+1} + v^{x+2}l_{x+2} + v^{x+3}l_{x+3} + \cdots + v^wl_w}{v^xl_x} \quad (11)$$

Symbol (D_x) represents v^xl_x , so substituting D_x in the above formula it reads:

$$a_x = \frac{D_{x+1} + D_{x+2} + D_{x+3} + D_{x+4} + \cdots + D_w}{D_x} \quad (12)$$

Commutation symbol N_x is used to indicate $D_x + D_{x+1} + D_{x+2} + D_{x+3} + \cdots + D_w$. The above formula, therefore, can be written:

$$a_x = \frac{N_{x+1}}{D_x} \quad (13)$$

Application of the Formulas. The net single premium for a \$1,000, twenty-year term policy issued at age 25 can be computed as follows, using the commutation columns (1958 CSO, at $2\frac{1}{2}$ per cent) and formula (8), and multiplying by \$1,000, the amount of the insurance.

$$A^1_{25:\overline{20}|} = \$1,000 \left(\frac{1754288.5116 - 1541435.3639}{5165007.9517} \right) = \$42.21 \quad (14)$$

The net single premium for a \$1,000 whole life policy issued at age 25 using formula (9) would be:

$$A_{25} = \$1,000 \left(\frac{1754288.5116}{5165007.9517} \right) = \$339.65 \quad (15)$$

For a twenty-year endowment issued at age 25, the net single premium for a \$1,000 policy using formula (10) would be:

$$A_{25:20} = \$1,000 \left(\frac{1754288.5116 - 1541435.3639 + 2978698.8164}{5165067.9517} \right) = \$617.92 \quad (16)$$

The net single premium for an immediate whole life annuity of \$1,000 a year issued at age 65 using formula (13) would be:

$$a_{65} = \$1,000 \left(\frac{13711704.0491}{1366128.5462} \right) = \$10,036.91 \quad (17)$$

Note how much simpler the arithmetic is in working out formulas (8), (9), (10), and (13) than would be the case in solving formulas (1), (2), (3), and (4). The use of the commutation columns greatly facilitates premium computations.

Formulas for Net Annual Level Premiums. The net annual level premium is computed by dividing the net single premium by the present value of an annuity due of 1 per annum for the premium paying period. For a twenty-year term policy, a twenty-year endowment, or a twenty-pay whole life policy, the net single premium is divided by the present value of a twenty-year temporary life annuity due. For a continuous-premium whole life policy, the net single premium is divided by the present value of a whole life annuity due. The formula for the present value of an n -year temporary life annuity due is developed as follows:

$$\ddot{a}_{x:\overline{n}|} = \frac{l_x + v l_{x+1} + v^2 l_{x+2} + v^3 l_{x+3} + \cdots + v^n l_{x+n}}{l_x} \quad (18)$$

If both the numerator and denominator of this formula are multiplied by v^x , the results are:

$$\ddot{a}_{x:\overline{n}|} = \frac{v^x l_x + v^{x+1} l_{x+1} + v^{x+2} l_{x+2} + v^{x+3} l_{x+3} + \cdots + v^{x+n} l_{x+n}}{v^x l_x} \quad (19)$$

Substituting the commutation symbol (D_x) in the above formula, it becomes:

$$\ddot{a}_{x:\overline{n}|} = \frac{D_x + D_{x+1} + D_{x+2} + D_{x+3} + \cdots + D_{x+n-1}}{D_x} \quad (20)$$

Since commutation symbol (N_x) is used to express $D_x + D_{x+1} + D_{x+2} + D_{x+3} + \cdots + D_{\infty}$, formula (20) can be written:

$$\ddot{a}_{x:\overline{n}|} = \frac{N_x - N_{x+n}}{D_x} \quad (21)$$

For the whole life annuity due, the formula is:

$$\ddot{a}_x = \frac{D_x + D_{x+1} + D_{x+2} + D_{x+3} + \cdots + D_{\infty}}{D_x} \quad (22)$$

Since the numerator in the above formula is the commutation symbol (N_x), the formula can be written simply:

$$\ddot{a}_x = \frac{N_x}{D_x} \quad (23)$$

The formula for the net annual level premium for an n -year term policy [formula (8) divided by formula (21)] becomes:

$$\frac{M_x - M_{x+n}}{D_x} \div \frac{N_x - N_{x+n}}{D_x} \text{ or } P_{x:\overline{n}|} = \frac{M_x - M_{x+n}}{N_x - N_{x+n}} \quad (24)$$

For an n -payment whole life policy, the formula is:

$$\frac{M_x}{D_x} \div \frac{N_x - N_{x+n}}{D_x} \text{ or } {}_nP_x = \frac{M_x}{N_x - N_{x+n}} \quad (25)$$

For an n -year endowment, the formula is:

$$\frac{M_x - M_{x+n} + D_{x+n}}{D_x} \div \frac{N_x - N_{x+n}}{D_x} \text{ or } P_{x:\overline{n}|} = \frac{M_x - M_{x+n} + D_{x+n}}{N_x - N_{x+n}} \quad (26)$$

For a continuous-premium whole life policy, the formula is:

$$\frac{M_x}{D_x} \div \frac{N_x}{D_x} \text{ or } P_x = \frac{M_x}{N_x} \quad (27)$$

Application of the Formulas. The net annual level premium for \$1,000, twenty-year term issued at age 25 would be:

$$P_{25:\overline{20}|} = \$1,000 \left(\frac{1754288.5116 - 1541435.3639}{139839496.9072 - 58927803.0828} \right) \text{ or } \$2.63^* \quad (28)$$

For a twenty-payment whole life policy, the premium would be:

$${}_{20}P_{25} = \$1,000 \left(\frac{1754288.5116}{139839496.9072 - 58927803.0828} \right) \text{ or } \$21.68^* \quad (29)$$

For a twenty-year endowment:

$$P_{25:\overline{20}|} = \$1,000 \left(\frac{1754288.5116 - 1541435.3639 + 2978698.8164}{139839496.9072 - 58927803.0828} \right) \text{ or } \$39.44^* \quad (30)$$

For a continuous-premium whole life:

$$P_x = \$1,000 \left(\frac{1754288.5116}{139839496.9072} \right) \text{ or } \$12.55^* \quad (31)$$

* Rounded off.

CHAPTER 22

Financial Management: Statements and Assets

The financial management and condition of an insurance company are a concern of the law, which not only sets rigid standards for the company's investments and disbursements, but which also makes its transactions subject to constant review by state regulatory authorities. In order for these insurance departments to obtain information which will enable them to judge whether a company is fulfilling the requirements of the law in its financial transactions and whether it is in sound condition as defined by the law, each company is required to submit a highly detailed annual statement. In the United States these statements are filed with the insurance department in each state and territory in which the company is licensed to do business. In Canada they are filed with the Dominion department, which assumes the primary responsibility for the solvency of companies licensed by it.

While the annual statements of companies licensed in a given state are on file with the department in that state and are public records, open to inspection by anyone on demand, the annual statement required by a state is designed primarily to provide information for the use of the department rather than to present the information in a form readily understandable by the layman. These statements are highly complex and do not follow the form customary in ordinary corporate annual statements.

The insurance company annual statement is further complicated by the fact that different state laws might require different information or different presentation of the same information. At one time in the history of regulation of the insurance business, every state had its own form, or "blank." Thus a company licensed in several states had to develop information for and fill out several different blanks. Since developing the information for and filling out an annual statement blank is a relatively expensive and complicated procedure, the use of different blanks requiring different information by different states was highly unsatisfactory. To remedy the problem, the National Association of Insurance Commissioners developed a uniform report known as the "convention blank," because the N.A.I.C. was then called the "National *Convention* of Insurance Commissioners." This blank was developed

in 1872 as one of the first projects of the newly organized association. With the exception of the "Gain and Loss Exhibit," the 1872 convention blank was used without revision until 1951. The "Gain and Loss" blank was revised in 1939. In its present form, the convention blank is accepted by all states as providing the information needed or wanted.

While the convention blank is uniform for all states, the financial statement for any given company may vary from state to state. Certain assets may be admitted in one state but not admitted in another.¹ At times in the past, different states have required different methods of valuing certain types of securities.² Other differences could be cited; but the point here is that there can be a variation in the financial statement of a company from one state to another even though the annual statement *form* used is the same for all states.

Insurance companies have been criticized from time to time for the complicated nature of their annual statements. Critics charge that the statements cannot be understood by policyholders and the public. Two points therefore need to be stressed: (1) The form of the annual statement is prescribed by state insurance departments, not by insurance companies. (2) As stated, insurance departments are interested in developing information that will enable them to judge the condition and transactions of companies in relation to the law. The information desired by the departments and the form in which they wish it presented may or may not be of interest or significance to the general public.

For policyholders and the public, all companies prepare and publish condensed annual statements in a form understandable to anyone who has a rudimentary acquaintanceship with corporate annual statements. Many companies develop attractive reports which have sound advertising and public relations values while at the same time presenting general financial and operational information of interest to the policyholder. The information given in these reports includes the surplus position of the companies, mortality and expense rates, net interest earned, the company's investment policy, and figures which show the extent of the company's growth.

In addition to the convention reports developed for the regulatory authorities and the annual reports developed for policyholders, companies prepare interim financial reports for the use of management. This chapter is concerned only with the reports required by state officials.

1. THE CONVENTION BLANK.

The convention blank as revised in 1951 calls for three different groups of statements:

¹ Admitted assets are those which the law of the state allows to be used to determine the excess of assets over liabilities.

² As in the years 1917-1921 and 1931-1933 when, because market prices were abnormally low, many states permitted valuation of nonamortizable securities at higher than market value.

- I Three financial statements
 - 1 Balance sheet
 - 2 Operations statement
 - 3. Surplus account
- II. Four miscellaneous statements
 - 1. Gain and loss exhibit
 - 2. Policy exhibit
 - 3. Interrogatories
 - 4. Deposit schedules
- III. Exhibits and schedules
 - Detailed information with respect to the summary figures used in the three financial statements.

Each of these statements will be discussed briefly.³

The Financial Statements. As in any business, the three most important statements are the balance sheet, profit and loss statement, and allocation of surplus.

The balance sheet for a life insurance company is given on pages two and three of the convention blank. In the form required, it is similar to the balance sheet of any type of business. Assets are given on the lefthand page and liabilities and net worth on the righthand page. Different sections of the balance sheet will be discussed later.⁴

The profit and loss statement is presented on page four of the blank in the form of a summary of operations. Income applicable to the period is stated whether actually received or not and from it are deducted expenses applicable to the period whether actually paid out or not. Income items consist of premiums, investment income, and net capital gains. Disbursements consist of policy benefits paid or payable, interest on policy or contract funds, increases in reserves, commissions, net capital losses, general operation expense, taxes, licenses and other fees, and dividends.

Allocation of surplus is shown on the bottom of page four of the blank as a double-column form. The lefthand column is a statement of the source of the surplus funds; for example, surplus carried over from the previous year, gains during the current year, and capital gains not listed in the summary of operations. On the right is detailed the distribution of surplus funds; for example, dividends to stockholders (if any), increase in contingency reserves, unassigned surplus, and capital losses not listed in the summary of operations.

The Miscellaneous Statements. The four miscellaneous statements are:

³ A detailed discussion of each of the items of an annual statement requires a development of a background of technical knowledge of both actuarial and accounting theory beyond the scope of this book, or of the course for which it is intended as a text. The purpose of this discussion is to acquaint the student with the general nature of the blank in order to facilitate understanding of company assets, liabilities, and surplus, and the problems of financial management.

⁴ Assets are discussed later in this chapter. Liabilities and surplus are discussed in the following chapter.

The gain and loss exhibit, appearing on pages five and six of the convention blank, is divided into two sections: operations by classes of insurance issued, and increases in reserves.

Operations by classes or "lines" is a breakdown of the items in the summary of operations, the second of the two financial statements described above. The purpose of the exhibit is to show the contributions of each of the following classes of business to the surplus of the company for the year.⁵

Industrial

Ordinary

Life insurance

Total and permanent disability insurance

Accidental death insurance ("double indemnity")

Annuities

Supplementary contracts

Group

Life insurance

Annuities

Health

Group

Individual

The section on reserves begins with a statement of the previous year's reserves for each "line" or subdivision included above, with the exception of health insurance. To the previous year's reserves are added assumed net premiums,⁶ assumed interest, and other increases. From the total are deducted assumed mortality, other costs, and payments on terminations.⁷ The remainder is the reserve as of the end of the year.⁸

The policy exhibit is divided into three parts:

Industrial

Whole life and endowment

Term

Dividend additions

Ordinary

Whole life and endowment

Term

Dividend additions

⁵ Remember these figures are *after* the payment of policy dividends and therefore represent net gains or losses.

⁶ Net premiums refer to valuation premiums without the expense loading.

⁷ Note the use of the terms "*assumed* interest" and "*assumed* mortality." These mean that if the reserve basis of the policy is 1958 CSO at 2½ per cent, then 2½ per cent and the 1958 CSO tabular mortality are used regardless of the actual interest earned or mortality experienced.

⁸ This is known as the "retrospective method" of calculating a terminal reserve which will be explained in detail in Chapter 23. Except for the fact that it is a part of the "Gain and Loss" exhibit, it can be ignored here.

Group
Annuities
 Individual annuities
 Group annuities
 Supplementary contracts involving life contingencies

The exhibit starts with a statement of the number of policies in force at the end of the previous year and the amounts involved. To this is added the number and amount of policies issued, revived,⁹ and increased during the year covered by the statement.

From the total arrived at are deducted policies which have become claims, matured as endowments, expired, surrendered, lapsed, decreased in amount,¹⁰ withdrawn, and terminated by disability.¹¹ The remainder is the number of policies and amounts of insurance in force as of the end of the year for which the statement is made ¹²

Under each of the divisions of the annuity section, the number of such annuities is listed, but, there being no "face amount" in the case of annuities, income payable, deferred payments fully paid, and deferred payments not fully paid are listed.

A note at the end of the exhibit gives the number of policies and the amount of insurance which has been reinsured.

The interrogatories section requests the answers to a series of forty-two questions about the company and its operations. Often these questions are designed for the purpose of gathering statistics on trends in the business and have little or no actual bearing on the financial position of the company. They might even be asked in connection with a study by the N.A.I.C. Blanks Committee for use in deciding whether more schedules should be added or others dropped. Examples of questions in the interrogatory section are the number, kind, and amount of the company's stock outstanding; whether or not the company has a retirement plan for agents and employees, in what states, territories, and countries the company operates.

Deposit schedules are of two types: special and general. In the special schedule are included deposits not available for the protection of all policyholders, such as a deposit required of a United States company for the exclusive protection of Canadian policyholders. The general deposit schedule includes a schedule of all other deposits.

Exhibits and Schedules. The third and final group of statements required on the convention blank are exhibits and schedules showing in detail

⁹ Lapsed policies reinstated.

¹⁰ Most of the decreases result from policies being put on the paid-up option

¹¹ Such termination arises under a type of policy that provides for payment of the face amount in installments commencing at the time of disability or maturing at age 65 in event the policyholder is continuously disabled prior to that age

¹² The statement also will show transfers from one form to another, the most common of which are conversion of term to whole life and the conversion of whole life to extended term.

information supporting the figures used in the financial statements. Briefly, the *exhibits* called for are as follows:

(1) Breakdown of premium receipts, dividends applied as premiums, premiums on reinsurance ceded, and commissions into the following categories:

- Industrial life
- Ordinary life insurance
- Total and permanent disability insurance
- Accidental death insurance ("double indemnity")
- Annuities
- Group
 - Life insurance
 - Annuities
- Health
 - Individual policies
 - Group policies

Figures in each category are divided into first-year, renewal, and single premiums.

(2) An analysis of investment income, derived by subtracting taxes, licenses, fees (computed in Exhibit 6), and investment expenses (computed in Exhibit 5) from the total interest, dividends, and real estate income (computed in Exhibit 3).

(3) A detailed report of total interest, dividends, and real estate income shown in Exhibit 2.

(4) Breakdown of capital gain and loss on investments by showing the increase or decrease in book value and the profit and loss on the sale or maturity of all investments of the company.

(5) Expenses incurred in life and health insurance investment operations.

(6) Taxes, licenses, and fees for life and health insurance investment operations.

(7) Analysis of dividends to policyholders.

(8) A detailed explanation of the reserves shown for the different types of life insurance policies outstanding.

(9) A detailed explanation of health reserves.

(10) Funds held by the company not involving life contingencies, such as limited installment option funds.

(11) A report on all outstanding life insurance claims in process and as yet unpaid.

(12) Determination of the amount of the company's ledger assets.

(13) Breakdown of all assets into ledger, nonledger, nonadmitted, and admitted.

(14) An analysis of nonadmitted assets.

The eighteen *schedules* are, briefly, as follows: ¹³

(A) A list of real estate owned and of real estate sold during the year. Real estate owned is divided into that owned at the beginning of the year and that acquired during the year. Information concerning description, cost, value, income produced, and expenses in connection with the property is required. Property is divided into farm and other and its value given by states in which it is located.

(B) A report of mortgages owned and changes made during the year. These mortgages are classified according to the states and foreign countries in which they are held. Also farm and other mortgages are handled separately. A distinction is made, too, between purchase-money mortgages and all other mortgages. Loans more than three months overdue but not yet in process of foreclosure, mortgages over \$250,000 or over one-half of 1 per cent of admitted assets, loans on which interest or taxes are delinquent for more than a year, and several similar items are listed separately. A detailed list of foreclosures during the year also is required.

(C) A schedule of loans secured by collateral.¹⁴

(D) A schedule describing the type, cost, book, market, par, and amortized values of stocks and bonds owned; purchased (or otherwise acquired); sold, redeemed, or otherwise disposed of during the year. Also included is the amount of income from stocks and bonds and the rate of earnings on stocks for the previous three years; a summary of bonds purchased during the year with their descriptions, name of seller, cost, and par value; a similar type of summary of securities sold during the year, including profit or loss.

(E) Balance in each bank account as of the date of the statement plus the highest balance in each such account during each month of the year and interest received on such accounts. Amounts on deposit in any suspended banks or trust companies are listed separately.

(F) A list of the amounts of all claims resisted or compromised during the year divided into (a) those disposed of and (b) those still in process at the end of the year. Claims are divided into death, disability, double indemnity, and other.

(G) Payments over \$500 made to trade associations, rating bureaus, service organizations; compensation paid to all officers and directors, amounts in excess of \$5,000 paid any individual, firm, or corporation except those included in Schedules I, J, and K. In the case of employees who are not directors or officers and who were paid under \$20,000, it is necessary to

¹³ For purposes of simplicity, these schedules are discussed in the order appearing on the blank. Notice, however, their illogical arrangement. For example, schedules H, N, and O deal with health insurance. Schedules A through E deal with assets and so does schedule X.

¹⁴ Few companies have any such loans outstanding.

show only the total number of such employees and the total amount paid them. In the case of any employee, whether an officer or director or not, who receives \$20,000 or more, the individual and amount must be shown.

(H) An analysis of health insurance experience with respect to premiums, claims, and expenses. The analysis segregates group from individual policies and further divides these classes into types of coverage.

(I) Commissions on loans and purchase or sale of property which exceed \$5,000, including name and address of the person receiving the commission and amount involved in the transaction.

(J) Names and addresses of persons paid legal fees of \$100 or more and reason for which the fee was paid. Amounts under \$100 are reported in total.

(K) Itemization of all expenditures made in connection with matters before legislatures and other government departments.

(L) A report of the last annual meeting: names of candidates for director and votes cast for each, and a copy of the minutes of the meeting.

(M) Examples of dividend rates paid during the year on the different classes of policies and a statement of the method by which the dividends were calculated.

(N) Premium and loss experience on various types of health policies.

(O) Analysis of health insurance claims arranged by types of coverages and broken down into amounts paid, unpaid, and estimated.¹⁵

(S) A list of amounts recoverable from reinsurance companies.

(T) Premium collections for life insurance and annuities classified by states.

(X) Unlisted assets, consisting of assets of doubtful or no value, with particulars about any property acquired, sold, or transferred to or from this schedule during the year.

New York sets a limit on the amount which may be used for expenses.¹⁶ In order to administer the law, the department in that state requires a "Schedule Q" showing details in connection with new business expense and, in the case of companies issuing participating forms, in connection with expenses as a whole. "Schedule Q" is not a part of the convention blank but is a New York state requirement for all companies operating in that state.

As stated, many of the schedules are detailed breakdowns or listings of figures required in the statements. Others require the information called for as a part of the general policy of publicity for all insurance company transactions. In these cases no restrictions are set by law. Instead, publicity is relied upon as a deterrent to improper practices. Thus, companies are allowed freedom of action in matters which might otherwise be subject to restrictions.

¹⁵ Estimated health claims are those incurred but not yet reported.

¹⁶ Wisconsin also limits expenses. See Chapter 27 for a discussion of the New York and Wisconsin expense limitations.

2. ASSETS.

Although the policy reserve of a life insurance company often is referred to as a "fund," it is simply a bookkeeping figure, actuarially determined, to measure the liability of the company under policy contracts outstanding. Thus the reserve is a liability; and it is necessary for the company to hold assets to offset that liability if the company is to remain solvent. Assets represent the values owned by the company which are available to offset liabilities and the ownership interest in the company.

Types of Assets. The instructions for filling out the annual statement blank state that "each class of assets should be entered . . . at its final value." To determine this final value, five terms relating to life insurance company assets must be defined: *ledger*, *nonledger*, *gross*, *nonadmitted*, and *admitted*.

Ledger assets arise from an excess of income over disbursements. In addition, they reflect any write-up of the value of an asset (which shows as income) and the value of any write-down (which shows as a disbursement). Examples of items included in ledger assets are cash on hand, real estate, mortgage loans, stocks and bonds, policy loans, and furniture and fixtures.

Nonledger assets are those to which a value is attached but which arise out of transactions not yet completed. Examples are interest due and accrued but not yet collected, and uncollected premiums due.

Gross assets are the total of ledger and nonledger assets.

Nonadmitted assets are assets which cannot be included in determining the solvency of the company, i.e., they cannot be counted in measuring the amount by which assets exceed liabilities. Examples of typical nonadmitted assets are any of the company's own stock which it may own or loans secured by the company's own stock; supplies on hand; furniture; advances to agents; the amount by which the book value of any asset exceeds the valuation as determined by the state insurance department.

Admitted assets are the net after nonadmitted assets have been deducted from gross assets. Expressed as a formula, *ledger assets + nonledger assets - nonadmitted assets = admitted assets*.

The final value of assets asked for on the annual statement blank is that of admitted assets.

Valuation of Assets. The admitted assets of a life insurance company consist mainly of stocks, bonds, mortgages, other types of loans, real estate, and cash. For the purpose of the annual statement, each of these assets must be assigned a value. If they are overvalued (or undervalued, for that matter) the statement will not be a fair measure of the company's financial condition. Therefore, care must be taken in ascertaining a fair value for admitted assets.¹⁷ Since the surplus of life insurance companies rarely exceeds 10

¹⁷ Liabilities must also be fairly valued. This is a subject for Chapter 23.

per cent of legal reserves,¹⁸ it also is important that valuation standards for assets be flexible enough to prevent unnecessary insolvencies during adverse market reactions.¹⁹ In many cases the state insurance department prescribes the method of valuation. Valuation problems in the past have been and still are being studied by both the industry and the regulatory authorities. The common methods of evaluating assets today are:

Cash. Obviously, the value of cash, on hand or in banks, is the dollar amount itself.

Loans. Loans are valued at face value, i.e., the amount lent plus accrued interest. Policy loans are fully secured since any default cancels an equal liability on the part of the company. Collateral loans (which, as stated, are rare among life insurance companies) are secured by the assignment of collateral equal to or exceeding the amount advanced. Mortgage loans likewise are secured by an asset (the deed to the property), which at the time the loan is made has a value in excess of the amount of the loan. The amount advanced on the mortgage is always substantially less than the appraised value of the property to allow a margin for a possible decline in its value. FHA and "GI" mortgage loans, on which a higher percentage of the appraised value is advanced, not only are secured by the property itself but also are guaranteed against loss by agencies of the federal government. If the value of the property at the time of a foreclosure is less than the unpaid balance on the mortgage, these agencies will, in effect, "make up the difference" to the lender.

Real Estate. Real estate held by a life insurance company may be classified into four types: (1) property necessary to the operation of the business; (2) property acquired in satisfaction of a debt (such as property obtained through the foreclosure of a mortgage); (3) property in the process of sale; (4) property purchased for investment income.

(1) Property necessary to the operation of the business—home office and branch office buildings, for example,—can be valued at cost, subject to write-ups and write-downs.²⁰ However, cost is not an altogether satisfactory method of valuation. In the case of a new building, the cost may have been

¹⁸ Most state laws restrict surplus accounts to 10 per cent of policy liabilities. Any surplus in excess of this amount must be paid in dividends

¹⁹ A mandatory securities valuation reserve (MSVR) was instituted by the National Association of Insurance Commissioners in 1951 as a prerequisite to the stabilization of asset values. A single reserve is required against bonds and preferred stocks, with *minimum* reserve requirements applying to bonds and preferred stocks. The annual increment required since 1951 has been $\frac{1}{20}$ of 1 per cent of the admitted value of amortizable bonds with the *maximum* fixed at 1 per cent, and 1 per cent of the admitted value of all nonamortizable bonds and stocks with the *maximum* set at 20 per cent. Furthermore, 100 per cent of net realized and unrealized capital gains are required. Net capital losses are allowable as a deduction, except for the years 1951, 1952, 1953, when the amount was limited to 50 per cent of such losses.

²⁰ Rarely, if ever, does an insurance company write up the value of its home office.

excessive. In the case of an existing structure, the price paid might have been too high. As a matter of fact, property is often sold to the highest bidder and, therefore, technically at least, more was paid for it than the purchaser could realize from an early resale. The local demand for business property may have fallen or risen since the property was acquired. The building may not have wide use by other types of business without costly alterations.

A second method of valuation is by appraisal. However, an appraisal is only an "educated guess" of the value at the time the appraisal is made, and since so many factors affect value, it would be necessary to have frequent reappraisals.

A third method of valuation is the cost of replacement if the building or buildings were reproduced at the present time exactly as they stand. From reconstruction cost is deducted accrued depreciation.

Perhaps the most widely used method of valuation of home and branch office property is the lesser of the following amounts: (a) capitalization of the earning power of the building and (b) original cost minus depreciation. Insurance companies often understate the values of their home office and branch office buildings in conformity with conservative accounting practices.

(2) Real estate acquired to satisfy a debt is valued twice: at the time of entry and at the time of the report.

For valuation at time of entry, several factors must be considered: (a) the amount of the unpaid principal on the foreclosure loan, (b) the cost of foreclosing, (c) the cost of clearing the title. Some authorities express the opinion that the amount of uncollected interest should also be included; but most hold that the interest, being a nonledger asset, should be included in a separate account so that the proper capital gain or loss can be determined.

For valuation at the time of the annual statement, reconstruction cost minus depreciation can be used, or the company may apply the same methods it uses in the valuation of its business property. If the property is residential and consists of less than four units, the reconstruction minus depreciation method is common; if it is a larger residential building or a commercial building or property, the method most common is that followed in valuing the company's own property (customarily book value less depreciation).

(3) Property in the process of sale; i.e., property being sold on installments, with title remaining with the company until final payment, presents the problem of handling the difference between the value of the real estate account and the amount for which the property is sold. There are three possibilities:

(a) Profit or loss can be withheld until the final payment is made.

(b) Profit or loss can be claimed when the purchaser has paid enough so that the balance due can be treated as a mortgage loan with the property as security.

(c) The difference between the value in the real estate account and the

amount for which the property is sold can be prorated over the life of the purchase, recording periodic changes in an account established for profit and loss on sales of real estate.

(d) Investment real estate may be valued in much the same way as real property necessary to the operation of the business. These properties, however, unlike home office or branch office properties, are not usually intentionally undervalued.

Nonamortizable Securities. Regulations of most states establish two classes of securities, nonamortizable and amortizable. A typical classification of nonamortizable securities includes all stocks because they do not have a definite maturity date or value, bonds in default as to principal or interest, bonds not amply secured, bonds yielding in excess of a given percentage on the current market, and bonds without a maturity date ("perpetual bonds"). Nonamortizable securities, with the exception of preferred stocks which meet certain earnings and dividend requirements, must be valued at their fair market price. The problem in this case is that of determining just what is the fair market price. Nothing reflects the market price of listed securities better than stock exchange prices; so these are generally used as the valuation basis. Actually, valuation of listed securities is left to the Committee on Valuation of Securities of the National Association of Insurance Commissioners, which promulgates annual valuation rules based largely on ratings in security manuals and current market prices. Customarily, the Committee recommends the market quotations as of December 31. Preferred stocks and nonamortizable bonds which are acquired through direct placement usually are valued at cost or capitalized earnings, whichever is lower.²¹ Unlisted stocks usually are valued at their last public sale price, or at the bid or asked price. If there have been no recent sales, common stock may be valued at book value.²² Insurance company stocks in some states must be valued at book; in others at market.

In 1957 the National Association of Insurance Commissioners adopted the "one-fifth rule" for the stabilization of the value of those preferred stocks

²¹ Direct placements are broadly defined as securities not offered for public sale, and include securities acquired directly from the issuers, securities acquired from investors who had acquired them from the issuers, and securities acquired from investment bankers or at competitive bidding when there was no public distribution. The first category represents the most important source of direct placements for life insurance companies. Direct placements account for more than 70 per cent of the corporate bonds held by United States life insurance companies at the present time. One advantage to the issuing corporation of direct placement is that the securities are exempt from registration with the Securities and Exchange Commission. Another advantage is lower distribution costs. The insurance companies (chiefly the large ones) find direct placement advantageous because it enables them to get a larger portion of the issue than they could obtain at a public sale. The small investor, however, is adversely affected by the rise of direct placement.

²² Book value of common stock is found by dividing capital plus surplus minus preferred stock by the number of common shares outstanding. In applying this formula, the surplus should not include reserves required by statute.

which meet certain dividend and earnings requirements. This rule allows life insurance companies to value qualified preferred stocks at a figure between the price quoted in the market on the last day of the year of the report and the amount shown in the statement for the previous year. One-fifth of the difference between these two figures is added to or subtracted from, as the case may be, the previous year's value. Thus, if a qualified preferred stock has a market value of \$80 a share on the last day of the statement year and was valued in the previous statement at \$90 a share, the value admitted in the new statement will be \$88 a share. If the situation were reversed, i.e., if \$80 in the previous year's statement is to be related to a current market value of \$90, the new statement value would be \$82 a share. Thus, fluctuations up and down in the preferred stock market are minimized in the valuation of qualified issues.

Amortizable Securities. In general, to be eligible for valuation on an amortized basis, a bond must not be in default as to principal or interest, must have a maturity date, must be amply secured,²³ and must fall into one of the following classes: (1) issued, assumed, or guaranteed by the United States or Canadian government; (2) special revenue bonds of a political subdivision or corporation bonds in the four highest grades of a recognized rating agency; (3) corporate bonds on which the yields to maturities do not exceed a given figure;²⁴ (4) approved by the National Association of Insurance Commissioners' Committee on Valuation of Securities; and (5) foreign bonds approved by the Committee.

Amortizable securities²⁵ are valued according to a procedure under which their original cost is written up or down by gradual stages until the book value equals par at maturity date.

A bond is a document certifying a debt of a specific amount of money payable at the end of a designated period. For example, a \$1,000 twenty-five-year bond certifies that a debt of \$1,000 is due twenty-five years from its

²³ The term "amply secured" does not necessarily mean secured by the pledge of specific assets but secured in the sense of being safe as indicated by a favorable working capital position and earnings record. The Commissioners set up certain tests for measuring the adequacy of the security.

²⁴ This is called the yield test. The test at this writing is that bonds based on association values in the current and preceding year should not yield more than 1.5 percentage points more than the yields on fully taxable United States Government bonds of comparable maturities. The theory behind this rule is that unusually high-yielding bonds often are not considered to be of good quality and for that reason their valuation on an amortized basis might be denied. The effect of this ruling is to require the use of market value. The yield on a bond is a function of the relationship between the interest payments and the market price. Since the interest payments are fixed, the yield increases as the price goes down. Therefore high-yielding bonds have low market values and these are the values which must be used for admitted assets.

²⁵ "Amortized value" in its strict or narrow sense refers only to bonds bought above par. The excess value is written down over the life of the bond so that the valuation at maturity date is par. However, the term is used in the trade (though technically incorrectly) to cover the reverse process, i.e., writing up, the technical name for which is "accrual of discount."

date of issue. The debt carries an interest rate known as the bond or coupon rate. If the above illustrated bond has a 4 per cent rate, it promises in addition to pay \$40 a year during each of the twenty-five years of its life. The \$40 is a fixed contractual obligation and will not vary during this twenty-five-year period. Perhaps interest rates in the market might rise to 5 per cent at one time and drop to 3 per cent at another, depending upon conditions in the money market. If the market rate rises above the bond rate, the bond will sell at a discount; i.e., the bondholder in a sale will have to accept less than \$1,000 for his \$1,000 bond. The reason is simple. If the purchaser paid \$1,000 for the bond, he would get only a 4 per cent return on money which is worth more than 4 per cent. Therefore, he would be willing to pay for the bond no more than that amount which would make the entire transaction yield him the market rate of interest.

For purposes of illustration, assume that the market rate of interest for this type of investment risk is 5 per cent. What will be the price of the bond in question? The price is the function of three factors: (1) the bond rate (4 per cent), (2) the market rate (5 per cent), and (3) the length of time until the bond matures (assume this to be ten years). Bond tables are published from which the price of the bond can be ascertained. A quick reference to one of these tables will give a price of approximately \$922. If an investor purchases a \$1,000 4 per cent bond due in ten years and pays \$922 for it, the investment will yield him 5 per cent. The effective annual return will be \$40 plus an annual write-up. On the straight-line method which gives approximate yields only, the annual write-up would be \$7.80. The \$7.80 annual accumulation (or write-up) is computed by dividing the bond discount (\$78)²⁶ by the number of years until the bond matures (ten). The \$47.80 gives an effective yield of approximately 5 per cent on a mean or average investment of \$961.²⁷ For valuation purposes, the bond will be entered at cost (\$922) when it is purchased, but will be increased in value by the write-up each year so that by maturity it will have reached a value of \$1,000.

If the market rate is 3 per cent instead of 5 per cent, the bond would sell at a premium. Assuming the other facts are the same as above, the bond would sell for about \$1,085.80. The annual amortization cost (write-down) would amount to \$8.58 on the straight-line method. This means that the effective earning each year is \$40 minus \$8.58 or \$31.42, which on a mean investment of \$1,047.90 yields an effective return of approximately 3 per cent. The bond will be valued at \$1,085.80 when purchased, but will be written down each year so that on its maturity date its valuation will be equal to its maturity value.

²⁶ The bond discount is the face of the bond (\$1,000) minus the price of the bond (\$922).

²⁷ The average investment (\$961) is the average of the initial investment of \$922 and the terminal investment of \$1,000. The annual interest received plus the increase in the write-up of the investment value (\$40 plus \$7.80) equal the annual return of \$47.80.

Amortization and accrual are common terms in valuation of bonds for any purpose, but the simple procedure described above is not an exact method. In connection with the valuation of life insurance company assets, the more correct method is commonly used, i.e., one which does not involve the same write-up or write-down every year as in the straight-line method. The actuarial method calls for an exact determination of write-ups or write-downs. Under this method the actual amount of effective interest deemed earned on the book value is computed. If the bond is a discount bond, then the excess of the effective interest over the bond interest is the write-up for the period. If the bond is a premium bond, then the excess of the bond interest over the effective interest is the write-down for the period. The tables may help to clarify the point.

TABLE 44

Discount Bond Illustration

Bond \$1,000—Bond Rate 4%
Purchase Price \$922—Effective Rate 5%
(Ten years to maturity)

<i>Years to Run</i>	<i>Initial Book Value</i>	<i>Bond Interest</i>	<i>Effective Interest</i>	<i>Write-up</i>	<i>Terminal Book Value</i>
10	\$922	\$40	\$46 10	\$6 10	\$928 10
9	928 10	40	46 41	6.41	934 51
8	934 51	40	46.72	6 72	941.23

TABLE 45.

Premium Bond Illustration

Bond \$1,000—Bond Rate 4%
Purchase Price \$1,085.80—Effective Rate 3%
(Ten years to maturity)

<i>Years to Run</i>	<i>Initial Book Value</i>	<i>Bond Interest</i>	<i>Effective Interest</i>	<i>Write-down</i>	<i>Terminal Book Value</i>
10	\$1,085 80	\$40	\$32 57	\$7.43	\$1,078 37
9	1,078.37	40	32.35	7.65	1,070.72
8	1,070.72	40	32.12	7.88	1,062.84

In these tables the value in the last column is the valuation used for the year in question. If the tables in these illustrations were to be carried to completion, the book value at the end of the tenth year would equal \$1,000, the maturity value of the bond payable at that time.

Efforts currently are being made to devise new and more realistic methods of valuation. Much progress has been made with respect to bonds, but a great deal of study needs to be given to stock valuation. More realistic valuation methods to many authorities mean methods that give less weight to liquidation values and more consideration to what might be considered stable, long-run values. After all, as will soon become apparent, life insurance

company investment portfolios do not require the liquidity assumed in the valuation formulas.

3. INVESTMENTS.

Life insurance companies are more than risk-bearing institutions. They are major financial institutions investing large sums of money every business day of the year. Their function as financial institutions is as important to the economy as their function as risk-bearing institutions.

The sources of new funds available for investment by life insurance companies consist chiefly of:

(1) Premiums collected in early policy years under the level-premium plan, which are in excess of those needed to pay claims and expenses.

(2) The accumulation of funds under the pure endowment portion of endowment and retirement income policies.

(3) Funds left with the company under policy settlement options.

(4) Various contingency funds accumulated out of expense loadings, excess interest earnings, investment profits, and mortality savings.

(5) Funds obtained from the sale of capital stock²⁸ and from paid-in surplus.

These funds could be held in cash to be paid out as required under policy contracts.²⁹ However, because the interest that can be earned on these funds significantly reduces the cost of the insurance, the funds are invested to yield a return. In anticipation of this return, the company guarantees a minimum rate of interest in computing its premiums, cash values, optional settlements, and on all funds left with the company.

Investment vs. Speculation. In order to understand the basic philosophy of life insurance company investment policy, a distinction must be made between *investment* and *speculation*.

The primary objective of speculation is a high rate of return, either in the form of large earnings or capital appreciation. Speculation has a definite place in the economy. It is a major source of developmental and entrepreneurial funds. For instance, it probably would be conceded that nothing is much more speculative than an investment in oil wildcatting. The over-all chance of a wildcat well coming in or of even hitting gas is one in nine. Yet, in view of the ever-increasing needs of the country—and of the world—for oil and the limitations on known oil deposits, wildcatting is a necessity. Since the average cost of such wildcatting is \$90,000 a drilling, speculative capital is important.

When money is placed primarily for the possibility of a large gain over a short period of time, the process is speculation. On the other hand, when the primary concern is for safety of principal, with dividend or interest return a secondary consideration, then the process may be called *investment*. It is

²⁸ Applies only to capital stock companies. See Chapter 24.

²⁹ The effects on the economy of a hoard of life insurance funds, however, would be drastic.

rare that a high degree of safety of principal and a high rate of return go hand in hand. They are usually at opposite poles.

The overwhelming majority of the assets of life insurance companies are funds held to meet contractual obligations under policies in force or under settlement options. In view of the guarantees made under these contracts, a life insurance company must be concerned first with safety of principal in dollars.

Legal Restrictions. The classes of investments permissible for life insurance assets are set by state law. In the main, they are confined to what may be called "first-lien" securities: bonds and mortgages, although limited investment in stocks and rental real estate are authorized.

The primary purpose of legal restrictions on life insurance company investments is to eliminate speculation and assure that the bulk of the funds, at least, will be placed in earning assets of a debt nature. This type of investment as a class is more likely to have a steady value. The law restricts investments in equities which as a class are subject to wide fluctuations in value. Such regulations also seek to prevent undesirable practices. For example, they prohibit officers or board members from making personal profits on any investment transaction they conduct for the company, and they prevent one individual from making secret investments by requiring that all investments be approved by the board or by a committee.³⁰

Investment Qualities Required. Safety is an important quality sought in life insurance company investment policy. In addition, companies want adequacy of yield, diversification, liquidity, and to some extent, a socio-economic purpose.

Safety. Inasmuch as the major portion of life insurance company assets is, as previously stated, held to meet reserve liabilities under contracts in force, the ability of the company to meet its policy obligations depends on the safety of its investments.

It is considered fundamental in life insurance company investment policy and the basic concern of laws relating to those investments, that investment should be preponderantly senior securities. Any substantial investment in equity securities is opposed because the values which life insurance policies guarantee are in terms of fixed amounts of dollars, whereas the values of equity investments are not fixed.³¹ Furthermore, as a rule principal is less safe in equity investments than in debt investments.³²

³⁰ Unfortunately, state laws, from time to time, have sought to direct life insurance investments into channels of interest of state legislators without much regard for the welfare of policyholders. An example is the Robertson Law in Texas, requiring the investment of assets equaling 75 per cent of the reserve liability on Texas policyholders in Texas securities.

³¹ The "variable annuity," of course, is an exception; it does not need guaranteed value investments since it does not guarantee a return in terms of a fixed number of dollars.

³² While the above is a general rule, the common stock of a corporation which has no other securities outstanding might well be safer than the junior bonds of another corporation with heavy senior commitments.

Adequacy of Yield. Inasmuch as the guarantees in a life insurance policy contract and the premiums for it are based on the assumption of a given rate of interest, it follows that yield is an important investment consideration for life insurance companies. The company must seek the highest rate of interest compatible with the required degree of safety in order to minimize the cost of insurance to policyholders. Moreover, human judgment not being perfect, it is not unrealistic to expect occasional losses in an investment portfolio. Thus, to offset possible capital losses, it is necessary for the company to earn on the average a rate of return in excess of the amount guaranteed by the policy contract.

As indicated in Chapter 20, the problem of adequacy of interest earnings has been an acute one for many years. In 1922 the net rate of interest, earned on life insurance company investments was 5.18 per cent. At that time it was common to guarantee policy rates of $3\frac{1}{2}$ per cent and even 4 per cent. Once such guarantees are made, they can of course never be reduced. From the high point in 1921, the net rate earned declined steadily to a low of 2.88 per cent in 1947. This was below the average rate guaranteed on all policies outstanding in some companies. Some of the losses had to be made up by reducing policyholder dividends and increasing premium rates on new policies.³³ Policies being issued today contain guarantees ranging for the most part from 2 per cent to $2\frac{1}{2}$ per cent. Although the interest rate has moved up somewhat since 1947, particularly over the past several years, and is currently running more than $3\frac{1}{2}$ per cent net after income taxes, the margin between the interest guaranteed on all outstanding policies and the interest earned could become a problem again. The result is that adequacy of yield is a major concern of life insurance company investments.

Diversification. Most states have recognized in their laws the fact that the safety of life insurance company investment portfolios is enhanced by diversification. Some states limit the proportion of assets which may be invested in any single type of investment. Companies have gone far beyond the requirements of law in securing diversification not only by classes of investments and within these classes, but also by geographical distribution and by maturity dates. In addition, investments of life insurance companies are diversified among industries, companies, types of security, and periods of the business cycle over which funds are committed.

Liquidity. Liquidity is the ability of an asset to be converted into cash immediately and without loss of value. Except for the relatively large sums left on deposit under options and supplementary contracts, which are subject to immediate call, liquidity is of relatively little importance as a standard for life insurance investments. In the first place, life insurance company commitments are long-term commitments, and therefore the assets held to meet

³³ Also used was the process of *reserve strengthening*. Under this process, lower interest assumptions were used in computing the reserve liability. The result, of course, was an increase in the reserve and a corresponding decrease in surplus.

those commitments can be long-term investments. Life insurance company investments are not purchased to be cashed out but rather to be held to yield income. In the second place, since investments are made every day, they mature at different times rather than all at once. In the case of any company in operation for any length of time, securities are maturing and are automatically converting into cash constantly. In the third place, cash receipts arising from premium income and investment earnings continue to grow so that, except in an extreme economic emergency,³⁴ the company always has cash income sufficient to meet cash calls. Finally, almost every policy written today contains, as a result of state law, a "deferment clause" permitting the company to postpone payment of any cash or loan value (except a loan to pay premiums) for a period of time, usually up to six months. The use of the deferment could help to prevent a serious loss resulting from a forced liquidation of assets if cash calls suddenly exceeded the amount of cash readily available.

Socioeconomic Purposes. Life insurance assets today represent a growing pool of capital and form one of the largest sources of funds in the country. There is a feeling in some quarters that at least a part of this pool should be used to expand the facilities of production on a risk-sharing basis—i.e., that it be put into equities. As previously mentioned, some states have authorized the investment of limited amounts of assets in preferred and common stocks and in housing projects and commercial real estate, but the percentage permitted is a small portion of the total assets of any one company, and hence of the combined assets of all companies.

Some companies are taking advantage of the opportunity to put money into equity investments, although life insurance companies, on the average, are not investing as much in common stocks and real estate as the law permits. It is entirely possible, however, that the time will come when growth, competition, and market conditions will force life insurance companies to move away from traditional forms of investment into the more venturesome types. The trend already is discernible. The companies might find that the higher yields on successful ventures will more than offset the losses on those that prove to be unsuccessful. Since liquidity is not too important, companies can ride with temporary setbacks in investment values.

Types of Investments. Life insurance investments are distributed among government securities, corporate bonds, mortgages, real estate, stocks, policy loans, and a few miscellaneous investments. Although the law restricts investments to certain classes and in certain amounts, life insurance companies have wide discretion as to their choice of investments among these classes. Wide variation among company investment portfolios will be found. The

³⁴ Such an emergency would have to be more extreme than that of the depression of the 1930's. During the depression years, total revenue of the business always exceeded total disbursements. In fact, premium income alone exceeded total disbursements in all but three years, 1932, 1933, and 1934. Cf. Table 1, Chapter 1.

suitability of each of these types of investment for life insurance funds deserves a brief discussion as a guide to an understanding of the composition of life insurance assets and the role played by life insurance companies in the capital market.

Government Securities. Traditionally, United States Government bonds offer the highest degree of dollar safety of any investment; but they also offer the lowest investment yields. Prior to World War I, few United States Government bonds were owned by life insurance companies. However, during both World War I and World War II, as their part in supplying the tremendous wartime demands on the government for money, companies invested heavily in United States Governments.³⁵ At one point during World War II, United States bonds represented about half of the total investments of the companies. Holdings of these bonds have decreased significantly since the war, as safe and higher-yielding private investments have become available. Today about 6 per cent of the assets of United States life insurance companies are invested in United States Government securities. This compares with nearly 46 per cent in 1945.

Specified Canadian Government bonds are eligible for life insurance company investments. Some states, however, limit the amount of assets that can be placed in such obligations. For instance, New York restricts the amount to 10 per cent of admitted assets unless the company has Canadian policyholders, in which case up to one and one-half times the assets necessary to offset the reserve liability on those policies may be invested in Canadian Government bonds. At present, less than 1 per cent of United States life insurance company assets are invested in Canadian Government bonds.

State, county, and municipal bonds vary in suitability. Many issues are acceptable, but they usually produce low yields. Less than 3 per cent of the assets of United States life insurance companies currently are invested in state and local bonds.

Corporate Bonds. Corporate bonds have long been an important medium for the investment of life insurance company funds. There are few restrictions on bond investments.³⁶ The only questionable class of corporate bond is the collateral trust bond, which is secured by shares of stock. It is a suitable life insurance company investment, according to some experts, only if the corporate shares used as collateral would themselves be suitable for investment.

³⁵ Aside from patriotic motives, life insurance companies purchased large amounts of government bonds during the war because these bonds were available as an investment outlet for the huge amount of investment funds being built up in the companies. If more profitable, safe investments had been available, life insurance companies probably would have purchased fewer government bonds.

³⁶ In fact, the Armstrong Committee recommended no restrictions at all on the investments in bonds, which indicates the suitability of such investments inasmuch as the over-all recommendations of the Committee were for vast restrictions in every phase of life insurance company operations. See Chapter 26 for further reference to the Armstrong Committee.

The only legal restrictions on bonds relate to those which are not fully secured or are in default as to the payment of interest.³⁷

Corporate bonds (railroad, public utility, and industrial) constitute about 40 per cent of the assets of life insurance companies in the United States.

Mortgages. In general, the mortgage loan is well qualified as an investment for life insurance companies. If an adequate margin has been maintained between the amount lent and the appraisal value of the property, the loan is well secured. Mortgage lending offers an opportunity for both geographical diversification and diversification of credit risks. Furthermore, it offers a relatively high rate of return of the degree of security involved. On the other hand, mortgage loans are relatively expensive to initiate and to service, and foreclosure in case of default is costly and sometimes harmful to public relations. One other disadvantage is the relatively short-term durations of many mortgages as compared with other investment media. Moreover, inasmuch as most mortgages can be paid off in advance, there is a tendency in times of falling interest rates for mortgage borrowers to "refinance" by paying off the old mortgage and making a new one at a lower rate of interest.

Prior to the depression of the 1930's, mortgages customarily were payable in a lump sum at maturity date. The depression popularized the monthly payment mortgage, which greatly increases the safety of the loan, since the margin between appraisal value and the debt constantly increases. The security of certain mortgage loans has also been enhanced since the depression by FHA insurance and the guaranteed "GI" mortgage of the Veterans' Administration.

In the eyes of most life insurance investment men, the advantages of mortgage lending outweigh the disadvantages. The total of life insurance assets invested in both farm and nonfarm mortgages is second only to investment in the securities of business and industry, running currently at about 34 per cent of assets.

Real Estate. At the present time, direct investment in real estate (other than for the company's own use) is the smallest of all classes of life insurance company investments (about 2½ per cent of assets), and few observers feel that it will ever become much more important.

Considered highly speculative, real estate was barred by law in almost every state as an investment for life insurance companies until the mid-1940's.³⁸ An insurance company was allowed to own only whatever real estate properties—such as home office and branch offices—it needed for the convenient transaction of its business plus any real estate it might have

³⁷ The New York law states that to be eligible, bonds must be adequately secured and not predominantly speculative. Bonds of corporations which have earned fixed charges 1¼ times for the three previous years are eligible per se.

³⁸ Virginia was one of the first states to pass legislation permitting life insurance companies to hold investment real estate. The law became effective in 1943.

acquired by mortgage foreclosure. Foreclosed real estate has to be disposed of in a specified period of time—within five years, for example, according to New York law³⁹

Today, all but a few states have laws permitting investment in real estate. The percentage of assets which can be invested in real estate, however, is limited, and many states prohibit investment in certain types of real estate, the exclusion list varying from state to state but including such prohibitions as hotels, agricultural property, mines, quarries, amusement enterprises, and clubs. The most liberal investment allowance made in any state is 20 per cent of assets, but this is the exception rather than the rule. Other states have much lower limits. New York permits a life insurance company to invest up to 10 per cent of its admitted assets in housing development, but restricts the investment in commercial real estate to 3 per cent of admitted assets.

Types of real estate in which life insurance companies have invested include retail stores, industrial sites, suburban shopping centers, supermarkets, office buildings, and the like. A popular type of investment transaction has been the purchase of industrial or business property from the industry or business, followed by a lease back to the former owner. The transaction releases working capital for the business,⁴⁰ as well as offering it certain tax advantages.⁴¹ Another type of investment, not widely used to date, is the purchase of the land upon which a building stands and then a lease back to the building owner. For example, an insurance company purchased from the building owners the land on which the Empire State Building stands.

Some states now allow life insurance companies to invest in apartment buildings up to a limited percentage of assets. Because housing developments create management problems, they are not considered desirable unless their size is huge. Inasmuch as the percentage of assets a company can invest in this type of project is limited, only the largest companies have shown interest in them.

A number of company investment men believe real estate in limited amounts has a proper place in a life insurance investment portfolio. They feel that even though there is an element of speculation, large and diversified portfolios make it possible to assume the risk without serious loss—especially since the amounts that can be legally invested in real estate are small in

³⁹ An extension of time usually is allowed if market conditions are such that a sale within the five-year period would work a hardship on the company.

⁴⁰ The sale and lease back of property enable the corporation to realize in working capital the full value of the building, whereas a mortgage loan would release only a given percentage of its value, usually not more than 50 per cent to 60 per cent.

⁴¹ The tax advantage arises out of the right of the tenant to deduct rents paid as a regular business expense. The profit on the sale of the building, if any, is taxed as a capital gain. The insurance company can deduct depreciation anew on the building based on the cost of the building to the company regardless of how completely the building was depreciated by its former owner.

comparison to total investments. Few, if any, however, contend that any substantial portion of assets should be invested in real estate.

Stocks. Stocks once formed a considerable part of life insurance company assets. The Armstrong investigation and the recommendations arising from it led to legislation that all but eliminated stock investment for many years. The investigating committee recommended that the state insurance law be amended virtually to prohibit investment of assets in any class of stock, common or preferred. That amendment was passed in 1906. Since most of the other states amended their insurance laws in light of the findings of the New York investigation, investment in stocks by life insurance companies was at a virtual standstill everywhere in the United States until 1928. In that year New York amended its law to allow limited and restricted investment in preferred and guaranteed issues. During the 1940's a number of states changed their laws to allow some investment in common stocks, and New York changed its law for that purpose in 1951. Today, only a few states prohibit investment in common stocks, although the percentage of assets that can be invested in common stocks is restricted. The current New York law restricts investments in common stocks to 5 per cent of admitted assets or one-third of the policyholder's surplus, whichever is lower. Not more than 10 per cent of the outstanding common stock of any corporation may be held. There are no restrictions on the amount of preferred stock that may be purchased so long as the issues meet the standards prescribed for them.

Stocks are generally considered to be speculative.⁴² On the other hand, advocates of limited common stock investment point to the size and diversification of life insurance company portfolios as a guarantee against any severe loss from common stock investing as well as from real estate investing.

One practical objection to investment in common stocks is the problem of fluctuating values. They must be valued at the official market price as determined by the N.A.I.C. Thus, a severe drop in market prices could reduce the surplus margin to a point which would make the company technically insolvent. Currently, about 4 per cent of all United States life insurance company assets are invested in stocks. Common stocks are responsible for nearly two-thirds of the total of stock investments.

Policy Loans. Policy loans are 100 per cent secured. Default on the loan results in cancellation of a like amount of liability under the contract. However, policy loans are not encouraged by life insurance companies. In the first place, most of them are in the category of "small loans," which are expensive to handle. In the second place, a policy loan may be a prelude to a lapse. Moreover, if money is not too tight, banks usually will lend money on the security of assigned policies at lower rates than the loan rate set in the

⁴² However, the argument has been advanced that selected issues of common stock can be more conservative investments than selected issues of medium and high-grade bonds. Cf. David McCahan, ed., *Investment of Life Insurance Funds*, Philadelphia, University of Pennsylvania Press, 1953, pp. 196 ff.

policy if the amount of the loan is reasonably large.⁴³ For these reasons, policy loans are not considered a primary investment medium. Currently, policy loans make up about 4 per cent of the assets of United States life insurance companies.

Miscellaneous Investment. Various minor investments may be held by life insurance companies. One example is collateral loans, of which few are made. Another is investment in transportation equipment—for example, railroad rolling stock leased back to the railroad. Life insurance funds have also been used in pipeline and toll-road financing and various other projects. Since the legislation of several states allows companies to invest a small percentage of assets without restriction, any type of investment or speculation might be found in the portfolios of companies controlled by these laws. For example, an Illinois company⁴⁴ once invested funds in a large quantity of cheese, hoping to make a profit from the increase in its value resulting from the aging process.

4. SUMMARY.

Life insurance companies are required to file certain types of financial information with the regulatory authorities on special forms designed by the National Association of Insurance Commissioners. These forms are called convention blanks and require three financial statements, four miscellaneous statements, and a number of exhibits and schedules. The assets entered in the financial statements are subject to regulation. Some assets are admitted; others are not. The values which are assigned to the assets are subject to state supervision so that the financial position of a company can not be overstated.

Life insurance companies are financial institutions as well as risk-bearing institutions. They invest large sums of money every day of the year. The important investment attributes which they seek are safety of principal, adequacy of yield, and diversification. In addition, some companies want to invest funds in channels that serve a socioeconomic purpose. Liquidity as an investment attribute is not too important to life insurance companies. The principal investment media for life insurance companies are corporate bonds and mortgages. To a much lesser extent, life insurance companies invest in government bonds, corporate stocks, and real estate.

QUESTIONS FOR CLASS DISCUSSION

1. Describe the nature and purpose of the *summary of operations and allocation of surplus* statements.

⁴³ The life insurance company, setting a loan rate by contract, is bound to that rate no matter what the conditions of the loan market are at the time the loan is made. It is also bound to charge the same rate on small loans as on large ones. Therefore, the contractual rate must be large enough to handle the high cost of making small loans. (One large life insurance company, while fixing a maximum loan rate, does scale down this rate as the amount borrowed increases, but the practice is rare for the reasons stated in the foregoing part of this footnote.)

⁴⁴ Illinois companies may invest 5 per cent of their assets in anything they wish.

2. Why is it important to have valuation standards for insurance company assets?
3. Describe what you consider to be the principal asset valuation problem of life insurance companies today.
4. Describe what you would consider to be a typical investment portfolio of a life insurance company.
5. Why might direct placements create a more difficult problem of asset valuation than created when securities are purchased at public sale?
6. Why are some assets not admitted?
7. Why do insurance companies acquire such a large percentage of their bonds through direct placements?
8. Why does the one-fifth rule not apply to the valuation of common stocks?
9. Why is liquidity not a major consideration in the investment of life insurance funds?
10. Explain how life insurance funds may be invested for a socioeconomic purpose.

CHAPTER 23

Financial Management: Liabilities and Net Worth

In the preceding chapter, the nature and problems of assets were discussed. The other side of the accounting equation, *assets = liabilities and net worth*, is the subject of this chapter.

1. THE NATURE OF LIABILITIES AND NET WORTH.

The concept of a "liability" at first seems a bit tricky, for it is not something that can be touched or seen. It is simply a figure on paper which serves as a yardstick for measuring the adequacy of assets. If assets are not sufficient to offset liabilities, the company is technically insolvent.¹ A liability exists wherever a company is "liable" (bound or obligated) to pay out assets now or in the future. Policy reserves are the principal liability of a life insurance company. They measure the net accrued liability of a company with respect to future benefits.

The concept of "net worth" is not difficult. It represents the ownership interest in the business. It follows that this figure is the difference between what the business owns (its assets) and what it owes (its liabilities). It is composed of two items: surplus and capital.

Life Insurance Company Liabilities. The nature of the liabilities of a life insurance company can be clarified by a brief look at the items which appear on the right hand (or liability and net worth) side of a condensed annual statement for a typical company.

Policy Reserves. The reserve is the amount which, together with assumed future net premiums and interest, will be exactly sufficient to enable the company to pay all benefits (death and survivorship) as they become payable, if the company's experience is precisely in accordance with its assumptions relating to interest and mortality.² Policy reserves make up roughly

¹ It is true that a company actually could be solvent although its assets did not equal its liabilities, since the valuation of both assets and liabilities contain some element of uncertainty.

² Another way of explaining the concept of the reserve is to view it as the excess of the present value of future claims (a liability) over the present value of future net premiums (an asset), both figured on the basis of the interest and mortality assumptions used.

85 per cent of the liabilities of all United States life insurance companies

Policy Proceeds and Other Funds Left with the Company This item measures the value of proceeds left with the company under settlement options,³ dividends left to accumulate at interest, and deposits left with the company to pay future premiums. These are liabilities because they also measure the value of obligations of the company to its policyholders

Policy Claims. At the time the financial statement is prepared, there always will be claims reported but not yet paid, and claims incurred but not yet reported. Claims in the process of settlement must be evaluated and an estimate must be made for unreported claims.

Dividends. Since policy dividends are declared on December 31 for payment on policy anniversaries in the following year, and since policy anniversaries are distributed throughout the calendar year, the company must show on its annual statement a liability for dividends declared to policyholders. Dividends payable to stockholders must be shown as a liability if they have been declared but not yet paid.

Commissions, Taxes, and Expenses. At the time of the statement, various expenses incurred but not yet paid will have to be shown as a liability. Two important items here are commissions and taxes. Agents will have earned commissions which have not yet been paid. Also, many taxes, particularly income taxes, are payable after the end of a fiscal year; thus, the company will be liable in one year for taxes which have accrued in the preceding year.

Security Valuation Reserve. A mandatory security valuation reserve is maintained to offset possible adverse fluctuations in the value of security holdings. Although the law requires that this reserve be shown as a liability, it is actually more in the nature of a net worth item. It reduces unassigned surplus by earmarking part of it as a contingency reserve

Other Liabilities. Other liabilities include any liabilities not segregated under the above headings. Some items which might be included in this category are unearned investment income and dividends due but not yet paid. Amounts held for the accounts of others might be included here. Among these items are funds deposited by mortgagors to pay taxes and insurance on the mortgaged property, amounts due to reinsurers for premiums, and amounts due to the reinsured for claims. Whether any of the above items are included under other liabilities depends upon whether a separate classification has been set up for them.

Net Worth Items. The principal items in the net worth section of a life insurance company balance sheet are surplus and capital.⁴ The capital account, of course, appears only in statements of capital stock companies. The surplus is divided into special surplus funds and unassigned surplus. Special

³ Settlement options involving life contingencies are shown under policy reserves as a part of annuity reserves.

⁴ The Convention Blank (Chapter 22) does not provide a special column for net worth. Net worth items are called "below-the-line" items since they appear at the bottom of the liability page. Liability items are called "above-the-line" items.

surplus funds arise from the creation of contingency reserves. These reserves are voluntary as distinguished from the required policy reserve and the mandatory security valuation reserve.

Voluntary reserves are a restriction of surplus and are made for the purpose of conservative evaluation of unassigned surplus. They are not required by law, but result from accounting practices designed (when used properly) to show the true financial position of the company. Companies that set voluntary (or contingency) reserves low, actually may be overstating their free surplus position, whereas those that are overconservative in the creation of these reserves by overestimating them tend to understate their unassigned surplus position. Within certain ranges, the amount of voluntary reserves to create is an individual company problem to be handled by management as it sees fit. Voluntary reserves may be treated either as a liability or as a net worth item.⁵ While some types of voluntary reserves are more closely akin to liabilities, others are more closely akin to net worth. The present discussion groups all voluntary reserves under net worth, although it acknowledges that a thin line exists between some of these reserves and liabilities.

Voluntary Reserves. Voluntary reserves are set up for contingencies to provide a margin for safety. Sometimes the reserve is simply called a special contingency reserve and is created to offset adverse fluctuations in mortality experience or investment earnings. At other times it may be separated into several reserve accounts such as a mortgage valuation reserve, asset fluctuation reserve, investment reserve, mortality fluctuation reserve, and similar reserves. A special reserve called additional policy reserve, policy revaluation reserve, or reserve strengthening is found on the statements of some companies. This reserve is created to strengthen the reserve for those policies written at higher interest and mortality assumptions than the company now believes are realistic.⁶

Unassigned Surplus. Put in nontechnical terms, unassigned surplus, sometimes called free surplus, is the margin by which the assets of the company exceed liabilities, voluntary reserves, and capital stock, if any.

Capital Stock. The capital stock account represents the dollar value nominally assigned to shares issued to stockholders. This account, of course, is found only in stock companies and will not appear on the books of mutual companies.

2. THE POLICY RESERVE.

Policy reserves are the obligation of the company to its policyholders and must be set up as a liability and valued according to the laws of the state.

⁵ The same type of reserve may be treated as a liability by one company and as a net worth item by another.

⁶ Older companies, for example, may have on their books life insurance policies, annuities, and settlement options written at $3\frac{1}{2}$ per cent. The annuities and settlement options may be based on assumptions that overstate mortality. The policy revaluation reserve is designed to adjust for these liberal assumptions.

In understanding policy reserves, it is helpful to think in terms of individual policy reserves with the aggregate liability of the company being the sum of these individual reserves. Although this concept is false, as will soon be explained, it is, if carefully used, a helpful tool in explaining the nature of reserves.

It is common to refer to the reserve as a fund as though it were an asset. For the purpose of a nontechnical discussion, the misnomer is of little consequence; in fact, it is often difficult and awkward to avoid. However, it should be made clear that the reserve is not a "fund." As a liability, it is an accounting measure of obligations.

Definition of Reserve. The reserve is a liability representing that amount which, together with future net premiums and interest will be exactly sufficient to enable the company to meet all policy obligations as they fall due, assuming that the company's experience is precisely in accordance with its assumptions relating to mortality and interest.

Because it is common to think of the reserve as a "fund" and to refer to it as a "reserve on a policy," laymen tend to think of the reserve in terms of a reserve for each individual policy. This misconception has plagued life insurance since the days of Elizur Wright. As insurance commissioner of Massachusetts, Wright kept an account book in which he computed the amount of reserve that should be set up for each policy written in the state. This book was open to the public, and since the amount of the reserve was stated in dollar terms, it led policyholders to assume that the reserve liability so calculated represented an amount of money in which each individual policyholder had a vested interest.

Actuarially there is no such thing as a reserve for an individual policy. Note again the definition of the reserve: "The reserve is a liability representing *that amount* [not "those amounts"] which . . . will be exactly sufficient to meet *all* policy obligations. . . ."

The assets held to meet the reserve liability are held *in the aggregate* and for the benefit of *all* policyholders. They are in no way segregated. Wright's book of reserves led to tying surrender values of policies to the reserve. From then until passage of the Standard Nonforfeiture & Valuation Laws in the late 1940's, surrender values were calculated on the basis of the reserve, less a surrender charge.

Time of Valuation. The reserve at the beginning of the policy year is called an *initial* reserve. The reserve at the end of the policy year is the *terminal* reserve. For example, the reserve at the beginning of the twentieth policy year on continuous-premium whole life insurance issued at age 35 would be \$351.46 per \$1,000, based on 1958 CSO at 2½ per cent. This is computed by adding the net level annual premium (\$17.67)⁷ to the terminal reserve for

⁷ The net annual level premium (17.67) used here is the valuation net premium. It may or may not be the same as the net annual level premium to which the loading is added to get the gross premium charged the policy-holders. Only if identical interest

the nineteenth policy year (\$333.79). The terminal reserve for the twentieth policy year is the initial reserve (\$351.46), increased by interest at $2\frac{1}{2}$ per cent (\$8.79), and decreased by mortality costs (\$7.71) for a total of \$352.54.

When a life insurance company prepares its annual statement, it will have on its books policies issued on every business day throughout the year. Some policies will be just starting a new policy year whereas others will be reaching the end of their current policy year. It may be assumed that on the average, all policies are midway through their policy years, since an equal number should be scattered evenly on each side of the midpoint. The reserve at the halfway mark in a policy year is called the *mean* reserve, and is computed by averaging arithmetically the initial and the terminal reserves. The mean reserve for the twentieth policy year for continuous-premium whole life insurance issued at age 35 is \$352.00 per \$1,000, 1958 CSO at $2\frac{1}{2}$ per cent, and is computed by averaging the initial reserve of \$351.46 and the terminal reserve of \$352.54. Life insurance companies use the mean reserve for purposes of computing the aggregate liability on all policies in force as of the date of the financial statement.

Methods of Evaluating Reserves. The reserve liability of a company on its outstanding policies may be calculated in two ways: *prospectively* or *retrospectively*. One method looks at the reserve on the basis of what will happen in the future, whereas the other method considers what is assumed to have happened in the past. Either method, of course, will give the same result.

Reserves may be computed on a full net level-premium basis or on a modified basis. The full net level-premium basis is illustrated in this section.

Prospective Valuation. Viewed prospectively, the terminal reserve is the present value of *assumed* future claims minus the present value of assumed future net level annual premiums,⁹ both values computed on the basis of assumed rates of interest and mortality.¹⁰ The equation might be stated thus:

The present value of assumed future claims minus the present value of assumed future net level annual premiums equals terminal reserve.

Steps in calculating the reserve by the prospective method are these:

Step 1: Based on \$1,000 of insurance, determine the present value of assumed future claims for the age at which the reserve is computed. (This step involves the same procedure as the computation of a net single premium for \$1,000 of insurance issued at the age at which the policy reserve is being computed.)

Step 2: Based on \$1,000 of insurance, determine the present value of

and mortality assumptions are used in both computations will the two net level annual premiums be the same and then only if the full net level annual premium reserve basis is used for valuation as distinguished from a modified basis. Bases for reserve valuations are discussed later in this chapter.

⁸ How the mortality cost is computed will be explained later.

⁹ "Net premiums" used here mean the net level valuation premium.

¹⁰ Assumed mortality and interest as distinguished from actual mortality experienced and actual interest earned.

assumed future net premiums to be collected from the age at which the reserve is computed (This is computed by multiplying the assumed net level premium by an annuity due of 1 at this age for the remaining premium-paying period.)¹¹

Step 3: Determine the reserve for \$1,000 of insurance by subtracting the results of Step 2 from the results of Step 1.

Step 4. Determine the reserve for all insurance of a given class by multiplying the results of Step 3 by the number of thousands of dollars of insurance in force in that class. (A "class" includes the age of the insured and the age and type of policy—for instance, an ordinary life policy issued at 25, in force ten years.)

The following are the steps involved in computing the reserve at the end of the second year on \$5,000,000 of continuous-premium whole life insurance issued at age 96. The net level premium per \$1,000 using 1958 CSO mortality at $2\frac{1}{2}$ per cent is \$482.91.

Step 1: Determine the present value of assumed future claims for the age at which the reserve is computed. At the end of the second policy year, the insured is age 98. So it is necessary to find the net single premium for \$1,000 of continuous-premium whole life insurance at age 98. This amounts to \$967.¹²

Step 2: Determine the present value of assumed net future premiums for the age at which the reserve is computed. To find this figure it is necessary to multiply the assumed annual net level premium \$482.91 by the present value of a whole life annuity due of 1 a year issued at age 98.¹³

Net level annual premium	..	\$482 91
Value of a temporary annuity due of 1 per		
annum for remaining period issued at age 98	1.32
Present value of assumed future net premiums		
(482.91×1.3237)	. . .	639.00

Step 3: Determine the reserve per \$1,000. This is found by subtracting the present value of future premiums (\$639) from the present value of future claims (\$967). It is equal to \$328.¹⁴

Step 4: Determine the aggregate reserve. This is determined by multiplying the reserve per \$1,000 by the number of thousands outstanding (5,000), giving an aggregate terminal reserve of \$1,640,000.

Retrospective Valuation. Viewed retrospectively, the reserve is the accumulated value of the net level annual premiums collected less the accumulated value of all claims paid based on assumed rates of interest and mortality. The equation might be stated as follows:

Accumulated value of net level annual premiums minus accumulated value of assumed claims equals terminal reserve.

¹¹ This computation is explained in Chapter 21.

¹² Review Chapter 21 for the method of computation.

¹³ *Ibid.*

¹⁴ Rounded to the nearest dollar.

Steps in calculating the terminal reserve by the retrospective method are these.

Step 1: Assume that \$1,000 of insurance is written for the number living at age of issue as shown in the mortality table used for computing reserves.

Step 2: Tabulate the assumed number living at the beginning of each year from age of issue to the age at which the reserve is computed and multiply these figures by the net level annual premium for \$1,000 of insurance under the type of policy involved.

Step 3: Determine the accumulated value of the net level annual premiums by multiplying these premiums by the amount of 1 at the assumed rate of interest for the years involved and total them. (If the reserve is to be computed at the end of the tenth year, the first premium will involve ten years of interest; the second, nine; the third, eight; etc.)

Step 4: Tabulate the assumed number dying during each year from age of issue to the age at which the reserve is computed and multiply these figures by \$1,000 to find the amount of assumed claims.

Step 5: Determine the accumulated value of assumed claims by multiplying these claims by the amount of 1 at the assumed rate of interest for the years involved and total them. (If the reserve is to be computed at the end of the tenth year, the first-year claims will involve only nine years of interest, since claims are assumed to be paid at the end of the year.)

Step 6: Subtract the results obtained in Step 5 from the results obtained in Step 3 and divide by the number living at the end of the year for which the reserve is computed. This gives the reserve per \$1,000 of insurance.

Step 7: Multiply the results of Step 6 by the number of thousands of insurance in force in that class to obtain the aggregate reserve.

The following is an example of reserve computation under the retrospective method, using for illustration \$5,000,000 of continuous-premium whole life insurance issued at age 96. The reserve is calculated for the end of the second year. (The net level annual premium was computed earlier and found to be \$482.91.)

Step 1: It is assumed that \$1,000 of insurance is written for 63,037 people.

Step 2: Net level annual premium:

<i>Age</i>	<i>Number Living</i>	<i>Net Level Annual Premium</i>	<i>Aggregate Premium</i>
96	63,037	\$482.91	\$30,441,198
97	37,787	482.91	18,247,720

Step 3: Accumulated value of net level annual premiums:

<i>Aggregate Premium</i>	<i>Years Accumulated</i>	<i>Amount of 1 at 2½% ¹⁵</i>	<i>Accumulated Value</i>
\$30,441,198	2	1.0506	\$31,981,523
18,247,720	1	1.0250	18,703,913
Total accumulated value of net level annual premiums			\$50,685,436

¹⁵ See table of amount of 1 values.

Step 4. Assumed claims:

Age	Number Dying	Amount per Claim	Aggregate Claims
96	25,250	\$1,000	\$25,250,000
97	18,456	1,000	18,456,000

Step 5: Accumulated value of assumed claims.

Aggregate Claims	Years Accumulated	Amount of 1 at 2½%	Accumulated Value
\$25,250,000	1	1 0250	\$25,881,250
18,456,000	0	1 0000	18,456,000
Total accumulated value of assumed claims			\$44,337,250

Step 6: The reserve per \$1,000 of insurance:

$$\frac{\$50,685,430 - 44,337,250}{19,331} = \$328^{16}$$

Step 7: The aggregate reserve:

$$\$328 \times 5,000 = \$1,640,000$$

Note that the reserve is \$1,640,000, whether computed prospectively or retrospectively. The excess of the accumulated value of assumed net level annual premiums over the accumulated value of assumed claims always will be equal to the excess of the present value of assumed future claims over the present value of assumed future net level annual premiums. Either procedure measures the reserve liability of the company.

Modified Reserve Systems. A problem in the practical operation of a life insurance company is the high first-year expense of a policy as distinguished from expenses in subsequent years. These high first-year expenses exceed the expense loading in the first year's premium. Commissions to the agent, medical examination fee, cost of inspection reports, policy issue—all these add up to an amount of money far in excess of the cost of maintaining the policy in any subsequent year. The valuation of the reserve is tied up directly with the cost of acquisition for reasons that will appear in the following illustration.

Assume that the premium for a \$10,000 nonparticipating ordinary life policy issued at age 35 is \$190.00. The total first-year commissions (for the writing agent and the general agent) will be about \$104.50. To this must be added about \$7.50 for the medical examination, \$5.00 for the inspection report, and, assuming a 2 per cent rate, another \$3.80 for the state premium tax. These four items alone add up to \$120.80, without considering home office administrative expense. On the 1958 CSO Table the mortality expense at age 35 is \$14.10¹⁷ without the safety factor added (\$25.10 with the safety factor). Excluding home office costs but including the first-year mortality cost of \$14.10, a total of \$134.90 will be spent the first year. Since the premium collected is only \$190.00, only \$55.10 will be left to offset the re-

¹⁶ Rounded to the nearest dollar. 19,331 is the number living at age 98.

¹⁷ The mortality cost on newly selected lives is likely to be less than this estimate

quired first-year terminal reserve for the policy. If the company valued its reserves on the full net level-premium system,¹⁸ the required reserve liability at the end of the first year under the policy would be \$156 40, thus reducing the surplus by \$101.30. In subsequent years the actual cost of operation is less than the loading, and the high first-year cost can be amortized over the premium-paying life of the policy.¹⁹

Thus, the more new business a company writes, the greater is the drain on its surplus. In an established company with a large surplus, the drain is of no consequence; but in a newer company with a small surplus and a high proportion of new business to business in force, the drain may be serious. Required use of the full net level-premium valuation system could force some companies to limit the amount of new business written.

The problem of disproportionate first-year expense could be solved by charging a higher premium the first year; but this solution is not practical, since the sales forces and the buying public would object to it.

There is no actuarial or accounting reason why a reserve valuation system that takes into account the unlevel incidence of expense cannot be used. Actually, as long as the valuation system used produces a safe over-all reserve, it is sound.

In recognition of this fact and of the practical problems involved in the incidence of cost, modifications of the net level premium reserve valuation system have been developed, authorized, and successfully used by companies throughout the years. The most important of these are the *full preliminary term* and the *Commissioners Reserve Valuation Method*. The full preliminary term standard has theoretical interest. The Commissioners Reserve Valuation Method is the one most commonly used today by companies that do not use the full net level-premium system.

Full Preliminary Term. Under the full preliminary term system of valuation, no reserve is required at the end of the first year. For purposes of calculating reserves, the policy is looked upon as a one-year term policy for the first year. Thereafter it is regarded as the original policy, issued one year later, for a period one year shorter. For example, a twenty-payment life policy issued at age 35 is looked upon as a one-year term policy at age 35 plus a nineteen-pay life policy issued at age 36. A continuous-premium whole life policy issued at age 35 would be looked upon as a one-year term policy issued at age 35 plus a continuous-premium whole life policy issued at age 36.²⁰

Since there is no terminal reserve as of the end of the first year, the

¹⁸ The full net level-premium system of valuing reserves is the method used in the illustrations of the prospective and the retrospective reserve computations.

¹⁹ Illustrating the fallacy of the criticism that companies make money from lapses.

²⁰ It should be stressed that it is erroneous to say that the policy itself is a one-year term policy for the first year; it is only the reserve that is affected. The nature of the policy is that stated in the contract and is not determined by the method of valuing the reserve.

entire amount of the first-year premium is released for expenses and mortality costs.

Many states did not permit the use of the full preliminary term reserve system under any condition, and very few states that did allow it permitted its unrestricted use. While the amount of premium released under this plan for first-year expenses under a continuous-premium whole life plan may be justifiable, the amount that will be released under a higher-premium policy may be excessive. The agent's commission is a large part of the first-year acquisition cost for any policy. Because the continuous-premium whole life policy and certain other whole life policies carry relatively low premiums, the standard practice is to pay the top commission scale on them and to pay smaller commissions on higher-premium policies. Thus the combination of a relatively high premium on, say, an endowment form plus a relatively low commission will produce a large amount for expenses under the full preliminary term valuation—a larger amount than needed.

Commissioners Reserve Valuation Method. In view of the fact that the full preliminary term system of valuation is not satisfactory for all types of policies, modifications of it were developed. Under the Commissioners Reserve Valuation Method in use on most policies issued since 1948, and many before that time, the *minimum* standard requires an interest assumption of not more than $3\frac{1}{2}$ per cent (3 per cent in New York) and the use of the Commissioners mortality tables.²¹

Under this system of valuation, policies are divided into two classes: (1) those for which the premium charged is equal to or less than that charged for a twenty-pay life policy issued at the same age for a like amount; and (2) those for which the premium charged is in excess of that for a twenty-pay life plan issued at the same age and for a like amount.

The reserves on all policies falling in class (1) may be valued on a full preliminary term basis if the company chooses, while those falling in (2) require a partial reserve at the end of the first year. This reserve is equal to that amount which, if credited annually to the preliminary term reserve on a twenty-pay life policy, would equal the full net level reserve on the policy at the end of the premium-paying period. In other words, the first-year reserve equals the full net level-premium first-year terminal reserve for a pure endowment for an amount equal to the difference between the full net level-premium terminal reserve on the policy in question at the end of the premium-paying period and the terminal reserve on a full preliminary term basis for a twenty-pay life policy, valued at the same time. Perhaps two examples will help to clarify this point:

Example 1: A thirty-year endowment insurance policy, issued at age 25, would have a first-year terminal reserve equal to the full net level-premium first-year terminal reserve for a thirty-year pure endowment purchased at age

²¹ Note that this is a minimum valuation formula. A company may value its reserves more conservatively if it wishes, using any standard up to the full level-premium system.

25, of an amount equal to \$1,000 (the reserve at the end of the thirty-year period) minus the reserve at the end of thirty years for a twenty-pay whole life policy issued at age 25.

Example 2: The first-year reserve on a fifteen-pay whole life policy issued at age 25 would be equal to the full net level-premium first-year terminal reserve for a fifteen-year pure endowment, purchased at age 25, in an amount equal to the reserve of the fifteen-pay whole life policy at the end of fifteen years minus the reserve at the end of fifteen years of a twenty-pay whole life policy issued at age 25.

The Commissioners Reserve Valuation Method can be illustrated with a twenty-year endowment, the premium on which will exceed that of a twenty-pay whole life policy and therefore must be valued in class 2. Let us assume a twenty-year endowment for \$1,000 issued at age 35, CSO $2\frac{1}{2}$ per cent. The method of arriving at the reserve on such a policy is as follows:

Step 1: Determine the terminal reserve on the twenty-year endowment:—\$1,000 00.

Step 2: Calculate the terminal reserve on the full net level-premium basis for a twenty-pay life policy issued at age 35, CSO $2\frac{1}{2}$ per cent:—624.55.

Step 3: Subtract the results of Step 2 from the results of Step 1: \$1,000 — \$624.55 = \$375.45.

Step 4: View the results of Step 3 as the face amount of a twenty-year pure endowment. The net level premium, then, is found by dividing this amount by the present value of an annuity due of 1 for twenty years issued at age 35: $\$375.45 \div 15.4254 = \24.34 .

Step 5: The first-year reserve for the endowment policy will then be the equivalent of the full net level-premium terminal reserve for the pure endowment. This is computed by accumulating the pure endowment net level annual premium for one year with interest and survivorship as follows:

(a) Pure endowment net level annual premium	\$24.3400
(b) Interest at $2\frac{1}{2}\%$ (24.34×1.025)	.6085
(c) Survivorship $\left(\frac{23,528}{9,350,279} \times 24.9485\right)^{22}$.0615
(d) Terminal reserve for first year	25 0100

Terminal reserves for each succeeding year will be the reserve required for that year for a twenty-pay life policy valued on the full preliminary term basis, *plus* the accumulated full net level-premium terminal reserve for the pure endowment. At the end of the premium-paying period, the reserve will equal the full net level-premium reserve.

Actuarial Assumptions and the Size of the Reserve. In computing re-

²² The survivorship benefit is computed as follows: the number dying at age 35 divided by the number living at age 36 multiplied by the initial reserve plus interest. No mortality is charged here since this is a pure endowment.

serves the actuary must make assumptions relative to mortality and interest rates just as he must in calculating premiums. The actuarial assumptions need not be the same, however, for both computations. In fact, in nonparticipating insurance, it is quite common to use higher interest assumptions and less conservative mortality assumptions in computing premiums than in computing reserves.

Effect of Interest Assumptions on Reserves. The size of the reserve varies inversely with the rate of interest assumed in its calculation. The reason should be clear after a glance at the accompanying table.

The table shows that for each dollar desired, say fifty years hence, it will be necessary to deposit today approximately 18 cents, if the assumed rate of interest is $3\frac{1}{2}$ per cent; 23 cents if it is 3 per cent; 29 cents if it is $2\frac{1}{2}$ per cent; and 37 cents if it is 2 per cent. Thus, if interest rates move downward, reserves valued on the basis of a previously higher rate of interest will be inadequate. Conversely, an increase in interest rates will make redundant any reserves valued on the basis of a previously low rate of interest.

<i>Present Value of \$1.00 Due at End of Designated Number of Years</i>				
<i>End of Year</i>	<i>If 2% Is Assumed</i>	<i>If $2\frac{1}{2}$% Is Assumed</i>	<i>If 3% Is Assumed</i>	<i>If $3\frac{1}{2}$% Is Assumed</i>
5	\$0.9057	\$0.8839	\$0.8626	\$0.8420
10	.8203	.7812	.7441	.7089
20	.6730	.6103	.5537	.5026
30	.5521	.4767	.4120	.3563
40	.4529	.3724	.3066	.2526
50	.3715	.2909	.2281	.1791

The following tabulation will indicate the difference in reserves necessary under the 1958 CSO Mortality Table at $2\frac{1}{2}$ per cent and 3 per cent. Note that the reserve is higher at each year of valuation at $2\frac{1}{2}$ per cent than at 3 per cent. This would be true regardless of the type of policy, age of issue, and date of valuation.

<i>Terminal Reserve per \$1,000 of Continuous-Premium Whole Life Insurance Issued at Age 35, CSO</i>		
<i>Year</i>	<i>$2\frac{1}{2}$%</i>	<i>3%</i>
5	81.05	74.72
10	167.90	156.29
20	352.54	334.23

Effect of Mortality Assumptions on Reserve. At age 35, life expectancy under three different mortality tables are as follows:

American Experience (1843–1858)	31.78 years
1941 CSO (1930–1940)	33.44 years
1958 CSO (1950–1954)	36.39 years

Thus, each table reflects an improvement in mortality, and premiums based upon them also would reflect this mortality improvement. For example,

the net level annual premium for \$1,000 of life insurance issued under various plans at age 35 using $2\frac{1}{2}$ per cent interest assumptions would be as follows on the three tables.

	<i>Continuous-Premium Whole Life</i>	<i>20-Payment Whole Life</i>	<i>20-Year Endowment</i>
American Experience	\$22 37	32 68	43.91
1941 CSO	20 50	30 30	41 98
1958 CSO	17.67	27 24	40 44

What about the reserve? How does a change in mortality assumptions affect the size of the reserve? Actually, when mortality assumptions change, it is often hard to tell which way the reserves are going to bounce. The following tabulations show the reserve at various intervals for \$1,000 of insurance issued under various plans and different ages using $2\frac{1}{2}$ per cent interest assumptions.

*Terminal Reserve per \$1,000 of Continuous-Premium
Whole Life Insurance, Issued at Age 35, $2\frac{1}{2}$ %*

<i>Year</i>	<i>American Experience</i>	<i>1941 CSO</i>	<i>1958 CSO</i>
5	\$ 74.07	\$ 84 70	\$ 81.05
10	157 02	174 39	167 90
20	345 26	362 44	352.54

*Terminal Reserve per \$1,000 of Continuous-Premium
Whole Life Insurance, Issued at Age 50, $2\frac{1}{2}$ %*

<i>Year</i>	<i>American Experience</i>	<i>1941 CSO</i>	<i>1958 CSO</i>
5	\$128 99	\$129.46	\$126 09
10	260 85	257 76	251 94
20	511.15	495 96	485 44

*Terminal Reserve per \$1,000 of 20-Payment Whole Life
Insurance, Issued at Age 35, $2\frac{1}{2}$ %*

<i>Year</i>	<i>American Experience</i>	<i>1941 CSO</i>	<i>1958 CSO</i>
5	\$131.19	\$138.43	\$133 05
10	282.40	291 43	280 22
20	658.52	653.56	624.55

*Terminal Reserve per \$1,000 of 20-Year Endowment
Insurance, Issued at Age 35, $2\frac{1}{2}$ %*

<i>Year</i>	<i>American Experience</i>	<i>1941 CSO</i>	<i>1958 CSO</i>
5	\$ 193.47	\$ 202.37	\$ 204.83
10	419.08	430.71	435 25
20	1,000.00	1,000.00	1,000.00

A glance at the above table will reveal that a given change in mortality assumptions will not affect reserves in the same manner on all plans of insurance, at all issue ages, and on all valuation dates.

For continuous-premium whole life insurance, the steepness of the slope of the mortality curve from age of valuation rather than the level of mortality determines the size of the reserve. For example, if the assumed rate of

mortality remained constant from age to age, there would be no terminal reserve regardless of the level of mortality. But the assumed rate of mortality increases with age; so there will be a terminal reserve, the relative size of which will depend upon how quickly the rate of mortality rises. The more rapid the rise in the mortality rate, the higher will be the reserve.

On single-premium whole life insurance, the size of the reserve is affected both by the level of mortality and the slope of the mortality curve. For limited-payment whole life policies, again both the level of mortality and the extent of the rise in the mortality rate will affect the size of the reserve, with the slope of the mortality curve being less important as the length of the remaining premium-paying period decreases.

The reserves on term and endowment insurance also are affected by the level of mortality as well as by the slope of the mortality curve. The longer the period of the unexpired term at the date of valuation, the greater will be the relative effect of the slope of the mortality curve.

Thus, the reserve valuation as reported by any company is determined by both the interest and the mortality assumptions used. Unrealistic interest or mortality assumptions can reduce the effectiveness of reserve requirements by producing an unrealistic reserve valuation. For this reason, the minimum valuation is specified by law. By specifying the minimum valuation, the law controls the reserve and thus gives at least some assurance to policyholders that the company will be able to meet all contractual obligations as they fall due. Such is the etymology of the term, "legal reserve company"; i.e., a company which maintains assets equal to the reserves required by law.

3. NONFORFEITURE VALUES.

The Standard Nonforfeiture and Valuation Laws ("Guertin Laws") take recognition of the fact that there is no pro rata relationship between the reserve and individual policies. Minimum surrender values, therefore, are defined without reference to the reserve. The laws recognize that a surrendering policyholder has made an "advance" premium contribution and should be entitled to a refund. This "refund," or nonforfeiture value, is determined according to a formula which produces a *minimum* nonforfeiture value required by law. A company may grant a higher value if it wishes. Since the nonforfeiture values are separate from the reserve, the reserve can be changed without affecting nonforfeiture values—which later are a matter of contract.²³

The Adjusted Premium. The *minimum* nonforfeiture value is based on an "adjusted premium" rather than on the net level premium used in reserve computations. The purpose of adjusting the premium is to amortize the as-

²³ Under the Standard Valuation Law, reserves can be greater (never less) than the nonforfeiture values, but for participating insurance the valuation interest rate can not be less than the nonforfeiture interest rate by more than $\frac{1}{2}$ per cent unless there is a plan for surrender dividends. Surrender dividends are settlements paid on policies terminated by surrender and consist of a return of part of the policyholder's contribution to the surplus of the company which has accrued during the years the policy has been in force.

sumed excess initial expenses (acquisition costs) of the policy over the premium-paying period. The adjusted premium is based on the three factors generally used in rate-making: mortality, interest, and expense, in contrast to the net premium, which is based on only two of these factors, mortality and interest.

In order to determine the adjusted premium, the assumed excess initial expense must be figured. For the purpose of computing *minimum* nonforfeiture values, the maximum amount of these assumed expenses is restricted by law. The excess of first-year expense assumptions may not exceed: (1) \$20 per \$1,000 of insurance, plus (2) 40 per cent of the adjusted premium for the policy using the interest and mortality assumption employed in computing nonforfeiture values, plus (3) 25 per cent of the adjusted premium for a continuous-premium whole life policy issued at the same age and under the same conditions, or 25 per cent of the adjusted premium for the policy under consideration, whichever is less.²⁴

In no case can the adjusted premium used in the above formula exceed \$40 per \$1,000 of insurance. This limits the assumed excess first-year expense allowance to \$46 per \$1,000.²⁵ In addition, the law requires that the 1941 CSO Table with a 3½ per cent interest assumption be used in determining the legal minimum values.

The adjusted premium is determined by adding the net single premium (computed under nonforfeiture interest and mortality assumptions)²⁶ to the amount of the assumed excess initial expenses and then dividing by the present value of an annuity due of 1 for the premium-paying period. The adjusted premium lies between the *net* premium and the *gross* premium. It is more than the *net* premium, since it provides for the amortized assumed excess initial expenses. It is less than the *gross* premium inasmuch as it provides for only the assumed excess initial expenses and not for all expenses.

Minimum values are computed by the prospective method, i.e., the present value of projected adjusted premiums is subtracted from the present value of assumed future claims. The result is a nonforfeiture value that makes allowances for high initial expenses, and returns to the policyholder what is considered to be his just actuarial interest in the policy. If a surrender value is derived by the adjusted premium formula method before the end of the third year, companies are not required to pay cash values but, instead, may grant their equivalent in reduced paid-up insurance.

The other nonforfeiture options, extended term²⁷ and reduced paid-up insurance, are computed from the cash surrender values.²⁸

²⁴ Since the expense allowance is needed to compute the adjusted premium and the maximum expense allowance depends upon the adjusted premium, an algebraic equation must be developed to find the adjusted premium. These have been worked out for the usual line of policies, and tables of adjusted premiums have been published for them.

²⁵ $\$20 + [40 \text{ per cent of } \$40] + [25 \text{ per cent of } \$40] \text{ or } \$20 + \$16 + \$10 = \$46.$

²⁶ As distinguished from assumptions used in reserve computations

²⁷ The Guertin Laws allow the company to use mortality rates up to 130 per cent of the rates for other nonforfeiture values in figuring extended-term values. The allow-

Computing Nonforfeiture Values—an Illustration. To demonstrate the application of the above principles to a specific problem, we will calculate the minimum nonforfeiture value at the end of the fifth year for \$1 00 of twenty-pay whole life insurance issued at age 40. The assumptions used are 1958 CSO at 2½ per cent.

Step 1. Compute the adjusted premium for \$1.00 of continuous-premium whole life insurance issued at age 40. This has to be done algebraically because factors are used in computing the adjusted premium which depend upon the adjusted premium itself. The formula is as follows:

$$x = \frac{A + \$20/1,000 + .40x + .25x}{a}$$

where

x = adjusted premium for continuous-premium whole life at age 40

A = net single premium for whole life policy at age 40

a = present value of annuity due of 1 per annum age 40

Thus, solving the above equation:

$$xa = A + .020 + .65x$$

or

$$x = \frac{A + .020}{a - .65}$$

The net single premium for \$1.00 of whole life insurance issued at age 40 is \$.46713 and the present value of an annuity due of 1 per annum at age 40 is 21.84778.

Substituting these values in the above equation, the adjusted premium for \$1.00 of continuous-premium whole life insurance is found to be:

$$x = \frac{$.46713 + .020}{21.84778 - .65}$$

or

$$x = \frac{.48713}{21.19778} = $.02298$$

Step 2. Compute the adjusted premium for \$1.00 of twenty-payment whole life insurance issued at age 40 by the following formula:

$$y = \frac{A + \$20/1,000 + .40y + .25x}{b}$$

where

ance is made to enable a company to offset possible adverse selection under the extended-term option. The additional mortality assumption is widely used by small companies. In connection with the 1958 CSO Table, a special table, 1958 CSO-A table, was constructed to be used as a basis for extended-term values.

²⁸ Cf. Chapter 10.

y = the adjusted premium for the twenty-payment whole life policy issued at age 40

b = the present value of an annuity due of 1 per annum for twenty years
 A and x are the same as in Step 1.

Thus, working out the above equation:

$$y = \frac{A + .020 + .25x}{b - .40}$$

The present value of a twenty-year life annuity due of 1 issue at age 40 is 15.14887.

Substituting the values in the above equation, the adjusted premium for \$1.00 of twenty-pay whole life insurance becomes.

$$y = \frac{$.46713 + .020 + .005745}{15.14887 - .40}$$

or

$$y = \frac{.492875}{14.748875} = $.0334178$$

Step 3. Compute the present value of future adjusted premiums to be collected by multiplying the adjusted premium (\$.0334178) by the present value of a fifteen-year life annuity due of 1 at age 45 (12.04). This gives \$.40226. (Since the value is being computed for the end of the fifth year, fifteen premium payments remain starting at age 45.)

Step 4. Subtract the present value of future adjusted premiums to be collected (Step 3) from the present value of assumed future claims at age 45 (\$.51749) to arrive at \$.11523, the nonforfeiture value per dollar of insurance at the end of the fifth year. (The present value of assumed future claims is taken at age 45 since that is the valuation age.)

In Excess of Minimum Value. The above illustration produces the *minimum* nonforfeiture value based on the mortality and interest assumptions used. The actual value offered is frequently higher since many companies grant more liberal benefits than the law requires. This can be accomplished within the framework of the Standard Nonforfeiture Law by using lower excess initial expense assumptions than the law allows or by amortizing these expenses over fewer years than the premium payment period. When the adjusted premium is modified to produce higher surrender values, the modified premium is called a nonforfeiture factor. More than one nonforfeiture factor may be used in the same policy. For example, the policy might state: "Nonforfeiture Factor A shall be used in the calculation of values for the first two policy years. The value for any subsequent policy year shall be calculated by use of a factor reduced from Factor A by equal yearly decrements of an amount which will produce Nonforfeiture Factor B at the end of the fifteenth policy year or at the end of the premium-paying period if earlier, after which all cash values shall be the full reserve on the

basis of the 1941 CSO Table at $2\frac{1}{2}$ per cent valued on the Commissioners Reserve Valuation Method." Higher nonforfeiture values also can be provided by using a formula different from the standard nonforfeiture method. A number of companies still base nonforfeiture values on the reserve less a surrender charge as was common before 1948.

As long as the nonforfeiture values do not fall below the legal minimum, they may be computed by any formula the company wishes to adopt. The law does require, however, that the formula for computing surrender values be included in the policy.²⁹

Surrender options are discussed in Chapter 10.

4. HEALTH INSURANCE RESERVES.

In addition to life insurance reserves, companies writing health insurance report reserves for that class of business in their annual statements. Reserves for health insurance may be classified in two broad categories: (1) active life reserves and (2) claim reserves.

Active Life Reserves. Companies are required to maintain a reserve equal to the pro rata gross premium applicable to the period from the date of valuation to the next following renewal or premium due date. This "*unearned premium reserve*" is normally calculated as one-half of the aggregate gross premiums on policies in force at the date of valuation, on the assumption that policy anniversaries are evenly distributed throughout the year.

In addition to the unearned premium reserve, an *additional reserve* is normally required on policies under which the claim rate or average claim value increases with age. This *additional reserve* is required by law on non-cancellable and guaranteed renewable policies, and certain other types of policies under which the insurer's right to discontinue the insurance is restricted.

Reserves in addition to the unearned premium reserve are sometimes held for commercial policies under which the insurer has an unlimited right to cancel, to refuse renewal, or otherwise to re-underwrite the policies on renewal. While these additional reserves are important to sound insurance operations where a level premium is charged for an increasing risk, they are generally not required by law except for non-cancellable and for guaranteed renewable policies.

Claim Reserves. The active life reserves measure the amount which, with premiums to be received in the future, will be sufficient to provide for benefits under claims that will be incurred after the date of valuation, if future claims are incurred according to the assumptions on which the active life reserves are based. However, benefits to be paid in the future under claims incurred prior to the date of valuation are not provided for by the active life reserve. Consequently, it is necessary to establish the insurer's liability for such benefits separately from the active life reserve. This

²⁹ In some states the law has been modified to require the formula only for those durations for which the specific values are not shown in the policy.

liability has, basically, two elements: (1) *the claim reserve* and (2) *the policy claim liability*.

The *claim reserve* provides for the future contingent benefits under claims in existence at the date of valuation. Thus, the claim reserve provides for benefits for the period of disability that will follow the date of valuation. In some cases, especially where the maximum benefit period is of long duration and the claimant has remained disabled for a reasonably long period, say six months, the future period of compensable disability is estimated on the basis of a disability experience table representing the persistence of claims for disability.

The *policy claim liability* represents the insurer's liability for accrued benefits which would be due and payable except for completion of notice of claim and proof of loss. It differs from the claim reserve in that the liability is not contingent on the claimant's survival, his continued disability, or some other future condition. The liability has already been incurred and the policy claim is payable as soon as the formalities are completed. The claim reserve provides for benefits which are likely to accrue after the valuation date, whereas the claims under the policy claim liability already have accrued.

Claim reserves and policy claim liabilities arise under claims for which the insurer has not received notice on the valuation date (i.e., the so-called unreported claims), as well as claims reported to the insurer prior to the valuation date. The reserves and claim liabilities for unreported claims are estimated from past experience with the class of policies under which the claims are incurred.

Future experience under health insurance is difficult to predict with any great degree of accuracy. Claim rates and average benefits per claim exhibit considerable fluctuations and have been observed to vary with the economic cycle, as the result of epidemics and for other reasons. It is common, therefore, for companies to build up contingency reserves as a part of surplus in order to provide for adverse fluctuations in claim experience.

5. NET WORTH.

The final section of a life insurance company balance sheet deals with net worth. This section also ties in with the other two financial statements, *summary of operations* and *surplus account*.

Net worth is made up of capital and surplus. The vast majority of life insurance policies are written by mutual companies in which there is no capital stock. These companies are owned by the policyholders and their net worth is represented solely by surplus.

While it is common to speak of surplus as a "fund," and while it often requires circumlocution to refrain from doing so, it will be helpful in understanding the following discussion of surplus to hold in mind that it, like the reserve, is not a fund. When combined with capital, surplus is an accounting

figure showing the *net* ownership interest in the assets of the company.³⁰ In a financial statement, assets must equal liabilities and net worth. If after the liabilities and capital stock have been added together there are assets in excess of them, then what might be called a "balancing factor" is set up to "even accounts." That balancing factor is labeled "surplus."

Sources of Surplus. A company can experience gains or losses in surplus from six sources interest, loading, mortality, gains and losses in asset values, surrender of policies, and experience on health insurance contracts.

In the computation of its rates, a life insurance company assumes lower interest, higher mortality, and higher expenses than it anticipates it will experience. As a result, the company is likely to earn excess interest and experience savings on mortality and expenses which all go to increase surplus.

As explained in the preceding chapter, certain assets periodically are revalued according to market prices. When the statement value is increased, surplus is increased correspondingly. When the statement value is decreased, surplus likewise is decreased.

Surplus may be increased by a sale of assets for more than book value. It may be decreased when assets are sold at less than book value.

The surrender of a policy also may add to the surplus. As previously explained, when a policyholder surrenders his policy, he may not receive the full terminal reserve. If the full reserve is not paid upon surrender, surplus is increased by the difference between the reserve released and the cash surrender value paid. Naturally, when a liability³¹ is decreased more than is an asset,³² the surplus (balancing factor) will be increased.³³

In addition to mortality coverage, many life insurance companies also offer certain types of health insurance coverages—waiver of premium, monthly income disability, and medical expense. Gains and losses resulting from deviations between actual and assumed morbidity will increase or decrease surplus.

Surplus in the Balance Sheet. The surplus section of the balance sheet is divided into three parts: special surplus funds, capital paid up, and unassigned surplus.

³⁰ In a mutual company the concept of surplus as an ownership interest seems cloudy, since a policyholder, upon withdrawal, is not entitled to a pro rata interest in the surplus. In some companies he may be given a surrender dividend, but this dividend represents only a part of his contribution to surplus and is in no event a full return of his "theoretical" interest in the company. The surplus, therefore, represents the ownership interest only of those who remain. Actually, it is difficult to say what it is in terms of ownership, since if the company is dissolved, the surplus may revert to the state under the laws of escheat.

³¹ The reserve.

³² The cash used to pay the surrender value.

³³ This paragraph should not be interpreted to mean that lapses or surrenders necessarily make a profit for the company. They may simply restore surplus which had been previously depleted when the policy was issued.

The *special surplus funds* are contingency reserves as differentiated from liability reserves. Contingency reserves are set up to offset adverse mortality and investment experience. A liability reserve covers a future expenditure which the company knows it must pay. A contingency reserve is one set up to cover a payment which *might* occur in the future. It is held for safety purposes only, to meet adverse fluctuations (which actually are not expected to occur). In other words, a *liability reserve* is to cover a *known* future expenditure payment, whereas a *contingency reserve* is to cover a *possible* future cost. As explained earlier, some companies will report a particular reserve as a liability, whereas another company will report the same reserve as a special surplus.

The *unassigned surplus* is the remainder of the surplus which has not been earmarked for any specific purpose.

The balance sheet indicates only how large the surplus is as of the date of the statement. It does not show the nature and causes of any changes. The summary of operations and the surplus account section serve this purpose.

Gain and Loss in Insurance. In the computation of a gross level premium, the following items are taken into consideration: mortality, interest, and expenses. Thus, if a company experiences mortality and expenses as assumed, earns interest at the assumed rate, and increases or decreases its reserve according to the mortality and interest assumptions made, there would be no gain or loss from operations. This relationship can be shown as follows:

*Gross premiums plus assumed interest minus assumed expenses minus increase in reserves*³⁴ *minus assumed mortality equal no gain or loss.*

Since life insurance contracts are long range and thus subject to unknown and unforeseeable future contingencies, conservative rate-making demands the assumption of higher mortality, lower interest earnings, and heavier expenses of operation than actually anticipated. As a result, there should be operational gains. For clarification, however, the term "gain" should be defined to eliminate misconceptions.

The immediate result of a gain is to increase surplus. In the case of nonparticipating policies, these gains actually represent earnings and correspond to profit of an industrial firm. Therefore, in rating nonparticipating policies, assumed and actual experience must be as closely identical as possible in order to develop rates which are competitive with net participating rates.³⁵ Whereas reserves on nonparticipating policies must be valued according to the highly conservative standards set by law, premiums are calculated on realistic assumptions.

However, in the case of participating policies, gains are not all profits in the usual sense of the word because a certain portion is expected to be re-

³⁴ Or plus decreases in reserves, as the case might be.

³⁵ Gross rates minus dividends.

turned to the policyholder as a dividend. A margin for dividends is customarily loaded into the gross premium for participating policies

A large gain from operations is no standard in itself of operational efficiency. Because gains arise largely from the difference between assumptions and experience, a large gain can be developed simply by using highly conservative assumptions ³⁶ Since the gains of a life insurance company are the result of the difference between assumed income and disbursements and actual income and disbursements, the relationship can be rewritten as follows:

Gross premiums plus actual interest ³⁷ minus actual mortality minus actual expenses minus increase in reserves ³⁸ equal gain or loss.

The Summary of Operations Statement. The above relationship is what is actually effected in the summary of operations statement.

First, the gross premiums accrued are determined by adding together the premiums on annuities, life, health, supplementary contracts with life contingencies, and supplementary contracts without life contingencies (period certain in settlement options, etc.).

Next, the interest actually earned is added to the gross premiums. This interest is determined by adding the net investment income (interest less taxes, investment management expenses, and other such expenses) and the net capital gains.

Then costs of claims are deducted by subtracting payments made such as death benefits, matured endowments, annuity benefits, disability benefits, sickness benefits, and disbursements under supplementary contracts (with and without life contingencies).

Following this operation, deductions are made for general insurance expenses; taxes, licenses, and fees; commissions; and expenses of investigating claims.

Finally, allowance for increases and decreases in the reserve is made by subtracting the decrease in reserve resulting from policy terminations and adding the increase in reserves from advancing duration of old policies and the issuance of new insurance.

The result is the net gain from operations. The summary of operations section of the annual statement continues with a deduction for policy dividends.

The Surplus Account. It is the function of the surplus account to tie the results of the balance sheet and the summary of operations together to show both the gain and loss and the size of surplus as of the time of the statement. The surplus account tells, *first*, the source of funds and, *second*, their application.

³⁶ This is not to say that operational efficiency of a company cannot result in gains. The greater the efficiency, the more favorable will be the experience when compared to given assumptions.

³⁷ Including capital gains and losses.

³⁸ Or plus decreases in reserves, as the case might be.

The account is a double-columned statement. The left-hand side shows the source of surplus. It starts with the surplus at the end of the previous year, listing the unassigned surplus and the special surplus funds for that year. To the sum of these two figures is added the gain determined in the summary of operations after the deduction of the policyholders' dividends. Next is added any capital gain not included in the summary of operations. Last is added the amount, if any, of surplus paid in³⁹ during the year. The total of these items shows the source of surplus during the year.

The right-hand half of the surplus account shows the application of surplus during the year, i.e., how the surplus was used. The first item is the amount of dividends to stockholders. Next is added any increase in reserves resulting from any change in the basis of valuation. After this, the amount of special surplus funds at the end of the year is added. The remainder necessary to balance the account is the amount of unassigned surplus at the end of the year.

Distribution of Surplus. Two decisions must be made in the management of unassigned surplus: (1) how much should be allocated to divisible surplus and (2) how the divisible surplus should be apportioned among the individual policyholders.

The Divisible Surplus. Dividend scales are a matter of company philosophy. For competitive reasons, companies seek to maintain a liberal dividend policy but not at the expense of sound financial management. As policy reserves increase over the years, so must contingency reserves if the companies are to achieve their goal of a given relationship between the two. Therefore, the divisible surplus each year *on the average* must be less than the annual gains from mortality experience, investment results, and operational efficiency. Once a dividend scale is established, however, it is usually continued unchanged for as long as it is practical to do so. Thus the divisible surplus for any one year does not have any fixed relationship to the year-to-year increases in surplus. The dividend scale may be maintained by drawing on past accumulations when the current gain in surplus is insufficient to support it.⁴⁰ When gains in surplus are more than sufficient to maintain the dividend scale, the excess is retained in the surplus account. Companies prefer not to alter their dividend scales from year to year to reflect annual experience, because of the expense and inconveniences involved. Only when a clear lasting trend in annual surplus gains is discernible will a company change its dividend scale to reflect it. The new dividend scale, like the old, becomes the product of the wisdom and knowledge of company management.

³⁹ Only in rare instances will there be any surplus paid in during the year. Surplus paid in is to be distinguished from earned surplus. It is much like capital in that it is paid in by its owners to strengthen the company.

⁴⁰ New York law prohibits dividend payments during the first year of insurance unless the dividend was actually earned for the policy based on reasonable interest, mortality, and expense assumptions. (The problem here is determining what are "reasonable" expense assumptions.)

The New York law limits the amount of surplus which can be maintained to 10 per cent of the policy reserve or \$500,000, whichever is greater. This restriction prevents a company from building excessive contingency funds at the expense of its policyholders. The surplus restriction does not apply to companies writing only nonparticipating policies.

Apportionment of Dividends. The apportionment of dividends to stockholders is merely a matter of dividing funds available for dividends by the number of shares outstanding. This is exactly the same process as in the case of any corporation. Dividends on stock are equitably distributed when paid to stockholders in proportion to their shareholdings.

The problem of an equitable distribution of policy dividends is not so simple. First of all, policy dividends are not profits, but a return of an overcharge of premiums.⁴¹ To distribute them among policyholders in the same manner as profits are distributed among stockholders would be inequitable, since policyholders contribute in different proportions to expense loadings, mortality costs, and investment funds. The problem becomes one of constructing a formula for the apportionment of dividends among policyholders in accordance with the contribution of each to the divisible surplus.

In apportioning the divisible surplus, it would be unfair to base the distribution on any one factor such as face amount of the policy, size of the premium, or level of the reserve. For example, it would be unfair to distribute savings in expense loading on the basis of the face amount of the policy when the amount any policy contributes toward savings in expenses of operation depends in part on the size of its premium per \$1,000.⁴² Again, it would not be equitable to distribute excess interest earnings and investment gains among policies on a basis of either face amount or size of premium when the contribution of each policy to the total of these gains is in proportion to its investment values as measured by the policy reserve. A policy with a high reserve, for instance, certainly has contributed more to any excess interest earnings and investment gains than one requiring a low reserve or no reserve at all.

It would be inequitable to distribute gains from mortality on a basis of total premiums, the face amount, or the reserve. It might appear at first glance that distributions of mortality gains according to the face amount of the policy would be equitable. However, the contribution of each policyholder to mortality savings depends upon the amount-at-risk in his policy for that year; i.e., the difference between the face of the policy and the amount of the reserve.

Inequities, then, will always exist if an attempt is made to divide funds

⁴¹ Thus, in the annual statement the amount of policyholder dividends never actually enters surplus but is handled in the summary of operations.

⁴² Policies of high face amounts usually contribute more than policies of low face amounts since quantity discounts have not been the rule. There is, however, a trend today toward quantity discounts.

available for dividends on the basis of any single factor, a fact that has not always been recognized. In the early days of life insurance in America, dividend funds were divided among policyholders either arbitrarily or on the basis of premium payments. One of the earliest methods of dividend apportionment was to credit each policy with an additional amount of insurance equal to a given percentage of gross premium paid.

It should be understood that it is impossible to achieve complete equity in dividend allocation and retain the objectives of simplicity⁴³ and economy of operation. Mortality gains, excess interest earnings, and expense savings vary among policies on the basis of factors other than amount-at-risk, policy reserves, and size of premium. For example, the residence of the insured, his occupation, and the duration of the policy can affect the contribution of each policy to mortality savings. The interest rate in effect at the time premiums are paid would affect the contributions of each policy to interest earnings, and the amount of service required will affect the contribution of the policy to operational savings.

THE CONTRIBUTION PLAN. The objective, therefore, should be to obtain a practical degree of equity. The search for a more equitable method of distribution than a single factor or arbitrary method of distribution resulted in 1863 in the introduction of the *contribution plan*, worked out originally by David Parks Fackler, founder of the Actuarial Society of America, then assistant to Sheppard Homans, of the Mutual Life of New York, and later actuary for the Equitable Life Assurance Society of New York. The plan was based on the theory that a contribution of a given class of policies to the earnings of a company can be found within reasonable limits by the following process:

Credit the policy with

- (1) The initial reserve.
- (2) The excess of the loading for gross premiums over actual expense.
- (3) Interest for the year on Items 1 and 2 at the *actual* rate earned by the company.

Debit the policy with

- (1) The terminal reserve.
- (2) The cost of insurance at the *actual* (experienced) rate of mortality.

The credit balance resulting from this process is the basis upon which that particular policy is to share in the dividend. The credit, of course, is not returned as a dividend. Each policy is expected to make a permanent contribution to surplus. The dividend is the percentage of divisible surplus that the credit bears to the total of all credits developed.

The process involved in the Fackler plan (which originally provided directly for interest and mortality, being later modified to provide for loading

⁴³ Simplicity is important so that the formula can be explained to the interested policyholder in terms that he can understand.

as well) succeeded in giving the policyholder credit for excess interest earnings, excess loadings, and mortality savings in proportions equitable to contributions made to those factors. This plan is called the three-factor contribution system. The dividend produced by this system will vary among policies with age of issue, plan of insurance, and duration of the policy. High premium plans and whole life and endowment policies which have been in force for a while will be more affected by excess interest earnings and less affected by mortality savings than will low premium policies and whole life and endowment policies recently issued, since they will have larger reserves and thus less at risk per \$1,000 of face amount. The combined effect is that for all policies except term, dividends increase with policy duration insofar as interest is the dominant factor.

The contribution plan continues to be the basis of nearly every company's formula for the apportionment of policyholder dividends. In practice, a myriad of variations has arisen; but the basic Fackler principle carries through all of them. Most companies issuing participating plans make an attempt to distribute the dividends as equitably as is practical, so that dividends are apportioned largely according to the contribution of each policy to the funds available for dividends. Variations among dividend formulas, company by company, mainly are differences in actuarial philosophy rather than in actuarial principle.

THE EXPERIENCE-PREMIUM METHOD. If excess interest earnings decline heavily, policy dividends will decrease with duration, a condition not considered desirable from the standpoint of policyholder relations. The experience premium was introduced as a modification of the contribution system to spread the gains from mortality more evenly over the duration of the policy rather than have them weigh so heavily in the early years of the policy as is the case with the unmodified plan. The object is to reduce the extent of the reliance on excess interest earnings for dividends on policies which have been in force for relatively long durations. Under this plan, an experience premium is developed from realistic mortality and expense assumptions but with the conservative interest assumptions used in computing the actual premium payable. The annual dividend consists of the difference between the actual premium and the experience premium, plus the excess interest earned for the year. As the "realistic assumptions" prove unrealistic, they will have to be adjusted just as dividend formulas are adjusted under the unmodified plan from time to time.

6. SUMMARY.

Two types of reserves are found in the annual statement: liability reserves and contingency reserves. The liability reserves are to cover payments which *must* be made in the future, whereas contingency reserves cover payments which *might* have to be made. Policy reserves are the most important among liability reserves.

Policy reserves may be computed in two ways, *retrospectively* or *prospectively*. The *retrospective* method computes policy reserves by subtracting the accumulated value of assumed claims from the accumulated value of assumed net premiums using the assumed rates of interest and mortality. The *prospective* method looks at the future and considers as the policy reserve the difference between the present value of assumed future net premiums and the present value of assumed future claims. These reserves are the *terminal* reserves, which are the reserves at the end of the year. The reserves at the beginning and middle of the year are the *initial* and *mean* reserves, respectively. However, these reserves, valued on a net level-premium basis, are often modified to allow for the large amount of initial expenses in the first policy year.

Since passage of the Standard Valuation and Nonforfeiture Laws, completed about 1948, minimum nonforfeiture values are determined by the *adjusted premium* method. It uses a premium adjusted for initial expenses instead of a net premium in figuring the nonforfeiture values. Minimum surrender values are the differences between the present value of assumed future benefits and the present value of adjusted premiums using the CSO at $3\frac{1}{2}$ per cent.

There are six sources of surplus: excess interest, mortality savings, expense savings, gains in asset values, gains from surrendered policies, and gains in connection with health insurance. The balance sheet shows the size of the surplus as of the date of the annual statement; the summary of operations shows the amount of change in surplus over the past year. The surplus account combines the results of these two statements and shows their interrelationship.

Dividends to policyholders in life insurance are not derived from profits in the usual sense, but rather from an overcharge of premiums. The amount of dividends to policy holders is usually determined by the *contribution* plan which distributes dividends according to the amount that each policy has contributed to the amount available for dividends.

QUESTIONS FOR CLASS DISCUSSION

1. Compute the third year terminal reserve per \$1,000 of five-pay ten-year endowment insurance issued at age 30, using 1958 CSO at $2\frac{1}{2}$ per cent. Use the full net level-premium reserve and compute it first on the prospective method and then on the retrospective method. Explain why the answers are the same.
2. Compute the above reserve on the Commissioners Standard Valuation method. Explain the theory behind this method of reserve computation, i.e., why is such a method allowed?
3. Compute the minimum nonforfeiture value of the above insurance at the end of the third year.

- 4 Explain why a company which pays the highest policy dividends is not, per se, the most economical company in which to buy insurance.
- 5 Explain the problems involved in achieving equity in dividend distribution.
- 6 Explain why the experience-premium method of dividend allocation might be considered less scientific than the contribution system.
- 7 Explain why the reserve is controlled by the slope of the mortality curve rather than by the level of mortality for continuous-premium whole life insurance.
- 8 Does the level of mortality affect the reserve for any type of insurance? Explain
- 9 What are nonforfeiture factors and why are they used?
- 10 In what ways do health insurance reserves differ from life insurance reserves?

A Mathematical Note on Reserve Computation

In the appendix of Chapter 21, certain symbols were explained and then algebraic formulas were developed for and applied in the computation of net premiums. Algebraic formulas also can be used in the computation of reserves.

Symbols. The standard symbols used to express reserves are as follows:

- ${}_tV_x$ = the t th year terminal reserve for a \$1.00 continuous-premium whole life policy issued at age x .
- ${}_t\overline{n}|V_x$ = the t th year terminal reserve for a \$1.00 n -pay whole life issued at age x .
- ${}_tV_{x:\overline{n}|}$ = the t th year terminal reserve for a \$1.00 n -year endowment policy issued at age x .
- ${}_tV^1_{x:\overline{n}|}$ = the t th year terminal reserve for a \$1.00 n -year term policy issued at age x .
- A_{x+t} = the present value of projected future claims at age $x + t$ for a whole life policy for \$1.00 of insurance.
- $A_{x+t:\overline{n-t}|}$ = the present value of projected future claims for an n -year endowment policy at age $x + t$.
- $A^1_{x+t:\overline{n-t}|}$ = the present value of projected future claims for an n -year term policy at age $x + t$.
- $P_x.\ddot{a}_{x+t}$ = the present value of future net level annual premiums at age $x + t$ for a continuous-premium whole life policy.
- ${}_nP_x.\ddot{a}_{x+t:\overline{n-t}|}$ = the present value of future net level annual premiums at age $x + t$ for an n -payment whole life policy.
- $P_x\overline{n}|.\ddot{a}_{x+t:\overline{n-t}|}$ = the present value of future net level annual premiums at age $x + t$ for an n -year endowment policy.
- $P^1_x\overline{n}|.\ddot{a}_{x+t:\overline{n-t}|}$ = the present value of future net level annual premiums at age $x + t$ for an n -year term policy.
- ${}_tV$ = the t th year terminal reserve for any type of policy. (This symbol may be used in lieu of anyone of the first four symbols above.)
- P = the net level annual premium for \$1.00 of insurance issued at age x under any type of plan.

${}_tU_x$ = the accumulated value of net level annual premiums of \$1.00¹ paid for t years from age x .

${}_tk_x$ = the accumulated value of claims paid per \$1.00 of insurance for t years from age x .

The last four symbols are used in connection with computing reserves on a retrospective basis, whereas the first eleven are used in calculating the reserve from the prospective viewpoint.

Prospective Reserve Formulas. The prospective reserve is computed by subtracting the present value of future net level annual premiums from the present value of future claims, as of the valuation date using given mortality and interest assumptions. The following are the formulas for computing the reserve for various types of policies.

The formula for the full net level-premium terminal reserve on a continuous-premium whole life policy for \$1.00 is:

$${}_tV_x = A_{x+t} - P_x \cdot \ddot{a}_{x+t} \quad (32)^2$$

For an n -payment whole life policy the formula is:

$${}_t{}_nV_x = A_{x+t} - {}_nP_x \cdot \ddot{a}_{x+t-n-t} \quad (33)$$

If the policy is paid up, then the quantity ${}_nP_x \cdot \ddot{a}_{x+t-n-t}$ will be zero and the reserve will be simply A_{x+t} .

For an n -year endowment policy the reserve is:

$${}_tV_{x:n} = A_{x+t-n-t} - P_{x:n} \cdot \ddot{a}_{x+t-n-t} \quad (34)$$

For an n -year term policy, the reserve is:

$${}_tV_{x:n}^1 = A_{x+t-n-t}^1 - P_{x:n}^1 \cdot \ddot{a}_{x+t-n-t} \quad (35)$$

The commutation columns reproduced herein can be used to work out each of the above formulas.

Example 1. Calculate the tenth-year terminal reserve per \$1.00 of continuous-premium whole life insurance issued at age 25, 1958 CSO at 2½ per cent. Substituting the values of t and x in equation (32), the formula becomes:

$${}_{10}V_{25} = (A_{35} - P_{25} \cdot \ddot{a}_{35}) \quad (36)$$

¹ This is called a foreborne life annuity due. It is the value of an annuity due of 1 per annum accumulated by interest and survivorship benefits. For example, if 9,575,636 people aged 25 each contributed \$1.00 to a fund now and the 9,557,155 people who are alive at the beginning of the next year contribute another dollar, the fund will have grown to \$19,856,486.45 at the end of the second year. If the fund is then divided among the 9,538,423 people alive at the end of the second year, each survivor's share will be \$2.08. This would be the value of the symbol ${}_tU_x$ where t is 2 and x is 25.

² The numbering is a continuation of the numbers used in the appendix to Chapter 21.

Substituting from equations (9), (31), and (23) (found in the appendix to Chapter 21), the equation can be written:

$${}_{10}V_{25} = \left(\frac{M_{35}}{D_{35}} - .01255 \frac{N_{35}}{D_{35}} \right) \quad (37)$$

Using the commutation table, the equation becomes:

$${}_{10}V_{25} = \left(\frac{1659440.3563}{3949851.0856} - .01255 \frac{93906838.6413}{3949851.0856} \right) = \$.12175 \quad (38)$$

Example 2. Calculate the tenth-year terminal reserve for \$1.00 of twenty-payment whole life insurance issued at age 25, 1958 CSO at 2½ per cent. Substituting from equation (33), the formula becomes:

$${}_{20}\overline{10}V_{25} = (A_{35} - {}_{20}P_{25} \cdot \ddot{a}_{35} \overline{10}) \quad (39)$$

Substituting from equations (9), (29), and (21), the equation can be written:

$${}_{20}\overline{10}V_{25} = \left(\frac{M_{35}}{D_{35}} - .02168 \frac{N_{35} - N_{45}}{D_{35}} \right) \quad (40)$$

Using the commutation tables, the equation becomes:

$$\begin{aligned} {}_{20}\overline{10}V_{25} &= \left(\frac{1659440.3563}{3949851.0856} - .02168 \frac{93906838.6413 - 58927803.0828}{3949851.0856} \right) \\ &= \$.22813 \end{aligned} \quad (41)$$

Example 3. Calculate the tenth-year terminal reserve for \$1.00 of twenty-year endowment insurance issued at age 25, 1958 CSO at 2½ per cent from equation (34), the formula becomes:

$${}_{10}V_{25:20} = (A_{35:10} - P_{25} \overline{20} \cdot \ddot{a}_{35:10}) \quad (42)$$

Substituting from equations (10), (30), and (21), the equation can be written:

$${}_{10}V_{25} \overline{20} = \left(\frac{M_{35} - M_{45} + D_{45}}{D_{35}} - .03944 \frac{N_{35} - N_{45}}{D_{35}} \right) \quad (43)$$

Using the commutation tables, the equation becomes:

$$\begin{aligned} {}_{10}V_{25} \overline{20} &= \left(\frac{1659440.3563 - 1541435.3639 + 2978698.8164}{3949851.0856} - .03944 \right. \\ &\quad \left. \frac{93906838.6413 - 58927803.0828}{3949851.0856} \right) = \$.43473 \end{aligned} \quad (44)$$

Example 4. Calculate the tenth-year terminal reserve for \$1.00 of twenty-year term insurance issued at age 25, 1958 CSO at 2½ per cent. From equation (35), the formula is:

$${}_{10}V^1{}_{25} \overline{20} = (A^1{}_{35} \overline{10} - P^1{}_{25} \overline{20} \cdot \ddot{a}_{35} \overline{10}) \quad (45)$$

Substituting from equations (8), (28), and (21), the equation can be written:

$${}_{10}V^1{}_{25} \overline{20} = \left(\frac{M_{35} - M_{45}}{D_{35}} - .00263 \frac{N_{35} - N_{45}}{D_{35}} \right) \quad (46)$$

Using the commutation tables, the equation becomes:

$${}_{10}V^1{}_{25} \overline{20} = \left(\frac{1659440.3563 - 1541435.3639}{3949851.0856} - .00263 \frac{93906838.6413 - 58927803.0828}{3949851.0856} \right) = $.00659 \quad (47)$$

Retrospective Reserve Formula. The retrospective reserve is computed by subtracting the accumulated value of claims paid from the accumulated value of net level annual premiums collected, as of the valuation date using given mortality and interest assumptions. The formula per \$1.00 of insurance can be stated as follows:

$${}_tV = P \cdot {}_tU_x - tk_x^3 \quad (48)$$

The formula for ${}_tU_x$ (the accumulated value of net level annual premiums of 1 paid for t years from age x can be developed as follows:

$${}_tU_x = \frac{l_x(1+i)^t + l_{x+1}(1+i)^{t-1} + l_{x+2}(1+i)^{t-2} + \dots + l_{x+t-1}(1+i)}{l_{x+t}} \quad (49)$$

In order to be able to use the commutation columns to find the value of ${}_tU_x$, it is necessary to multiply the numerator and the denominator in the above equation by v^{x+t} . Since v is $(1+i)^{-1}$, the equation may be written as follows:

$${}_tU_x = \frac{v^x l_x + v^{x+1} l_{x+1} + \dots + v^{x+t-1} l_{x+t-1}}{v^{x+t} l_{x+t}} \quad (50)$$

And since the commutation symbol $D_x = v^x l_x$, the above formula becomes:

$${}_tU_x = \frac{D_x + D_{x+1} + \dots + D_{x+t-1}}{D_{x+t}} \quad (51)$$

Substituting the symbol N_x in the numerator of the above equation, the final formula is written:

* Refer back to the beginning of this section for the translation of these symbols.

$${}_tU_t = \frac{N_t - N_{t+t}}{D_{t+t}} \quad (52)$$

The formula for ${}_tk_t$ (the accumulated value of assumed death claims per \$1.00 of insurance for t years from age x) is developed as follows:

$${}_tk_x = \frac{d_x(1+i)^{t-1} + d_{x+1}(1+i)^{t-2} + \cdots + d_{x+t-1}}{l_{x+t}} \quad (53)$$

Again, in order to be able to use the commutation columns to find the value of ${}_tk_t$, the numerator and the denominator in the above equation must be multiplied by v^{x+t} with the following results:

$${}_tk_x = \frac{v^{x+1}d_x + v^{x+2}d_{x+1} + \cdots + v^{x+t}d_{x+t-1}}{v^{x+t}l_{x+t}} \quad (54)$$

And since the commutation symbol $C_x = v^{x+1}d_x$, and the commutation symbol $D_x = v^x l_x$ the above formula becomes:

$${}_tk_x = \frac{C_x + C_{x+1} + \cdots + C_{x+t-1}}{D_{x+t}} \quad (55)$$

Substituting the symbol M_x in the numerator of the above equation, the final formula is written:

$${}_tk_x = \frac{M_x - M_{x+t}}{D_{x+t}} \quad (56)$$

Substituting equations (52) and (56) in equation (48), the formula for computing retrospective reserves per \$1.00 of insurance can be written as follows:

$${}_tV = \frac{P(N_x - N_{x+t}) - (M_x - M_{x+t})}{D_{x+t}} \quad (57)$$

The commutation columns can be used in computing the reserve from this formula. In calculating the tenth-year terminal reserve on insurance issued at age 25, the only variable as among types of policies will be P .

Example 1. Calculate the tenth-year terminal reserve for \$1.00 of continuous-premium whole life insurance issued at age 25, 1958 CSO at 2½ per cent. Substituting in formula (57) from formula (31) and the commutation tables, the equation can be written as follows:

$${}_{10}V_{25} = \frac{[.01255 (139839496.9072 - 93906838.6413) - (1754288.5116 - 1659440.3563)]}{3949851.0856} = \$1.12193^4 \quad (58)$$

⁴ The slight difference between this figure and the amount arrived at in equation (38) by the prospective method arises from the rounding off process. The small differences in examples 2, 3, and 4 exist for the same reason.

Example 2. Calculate the tenth-year terminal reserve for \$1.00 of twenty-payment whole life insurance issued at age 25, 1958 CSO at $2\frac{1}{2}$ per cent. Substituting from formula (29):

$${}_{20}\overline{10}V_{25} = \frac{[.02168 \quad (139839496.9072 - 93906838.6413) - (1754288.5116 - 1659440.3563)]}{3949851.0856} = \$2.2810 \quad (59)$$

Example 3. Calculate the tenth-year terminal reserve for \$1.00 of twenty-year endowment insurance issued at age 25, 1958 CSO at $2\frac{1}{2}$ per cent. Substituting for formula (30):

$${}_{10}V_{25} \overline{20} = \frac{[.03944 \quad (139839496.9072 - 93906838.6413) - (1754288.5116 - 1659440.3563)]}{3949851.0856} = \$4.43463 \quad (60)$$

Example 4. Calculate the tenth-year terminal reserve for \$1.00 of twenty-year term insurance issued at age 25, 1958 CSO at $2\frac{1}{2}$ per cent. Substituting for formula (28):

$${}_{10}V_{25}^1 \overline{20} = \frac{[.00263 \quad (139839496.9072 - 93906838.6413) - (1754288.5116 - 1659440.3563)]}{3949851.0856} = \$0.00657 \quad (61)$$

CHAPTER 24

Types and Analysis of Life Insurers

Life insurance is written by three types of insurers, broadly classified as *proprietary*, *mutual*, and *state*. The chief difference among them is in the nature of ownership. Proprietary insurers are corporations owned by investors who purchase shares of stock for profit (capital gain and income). Mutual companies are in the nature of co-operatives, being corporations owned by the policyholders themselves, who hope to obtain their insurance at cost. State insurers are owned by the government, federal or state, as the case may be, which is, theoretically, ownership by all citizens of the state¹

It is the purpose of this chapter to analyze each type of insurer and, further, to analyze the variations among insurers of the same organizational classes.

1. STOCK AND MUTUAL COMPANIES.

About 90 per cent of all life insurance owned in the United States is written in stock and mutual companies. As between stock and mutual companies, stock companies are the predominant type, composing 89 per cent of the old line legal reserve companies.² Mutual companies, however, are predominant in the amount of insurance written, accounting for about 62 per cent of the amount of life insurance outstanding in these companies.

Nature of Stock and Mutual Companies. Proprietary insurance is issued by individuals operating through the structure of a corporation. Such corpora-

¹ In other fields of insurance, notably fire and marine, proprietary insurers include unincorporated, individual underwriters, each taking a portion of the risk. The best-known group of such underwriters is that operating through the facilities of Lloyd's of London. The system of individual underwriters is not, however, adapted to life insurance contracts because the insured must not be able to outlive the insurer. In fire and automobile insurance, unincorporated co-operatives are found organized as reciprocal exchanges. The reciprocal form is not adaptable to life insurance for the same reason that the unincorporated, proprietary form is unsuitable.

² The term "old line" has no real technical significance. The designation was adopted by the regular companies during the latter half of the nineteenth century to distinguish themselves from the new and, at the time, highly competitive fraternal. The old line company on the one hand, and the fraternal on the other, are organized under different sections of the insurance code. Since most of the fraternal were originally assessment insurance organizations, the term "old line" also is applied to indicate that the carrier is not an assessment company. "Old line" is widely used to designate legal reserve companies writing business for the general public. An old line company may be either a mutual or a stock company.

tions are called "stock companies." The individual shareholders of the stock company advance the money to organize an insurer, and, in return, they share in the profits and losses. The stock life insurance company functions in exactly the same way as any other incorporated business organization. Management control rests with the shareholders, who elect the board of directors, which, in turn, elects the executive officers.

A mutual insurance company is distinguished from a stock company in that voting control is technically in the hands of the policyholders, who elect the board of directors, which in turn, elects the officers of the company who supervise its operations. In case the premiums collected from policyholders prove to be more than needed to pay claims, establish legal reserves and needed surplus, and pay operating expenses, the excess is returned periodically as a policy "dividend" according to formulas devised to return to each policyholder his equitable share, as discussed in the preceding chapter.

At this point it becomes necessary to make a distinction between theoretical principle and practical effect

In a stock company the individual stockholders technically control the company through their votes for the board of directors, which, in turn, elects or appoints the managing officers of the company. In practice, however, stock ownership is usually so widely scattered that the actual managers of the corporation are those who hold a "working majority," an amount of stock sufficient to provide the majority of votes ordinarily cast at any meeting of stockholders. Often the "working control" is in the hands of management. (There are exceptions to these generalizations, of course.)

In a mutual company, control is technically in the hands of the policyholders through their vote for the board of directors. Practically speaking, few policyholders ever attend policyholders' meetings or bother to send a proxy.³ Therefore, the control of the organization is usually in the hands of the active managers of the business. Translated into plain language, *stock companies* often are controlled by two or three officers who control a working majority of the stock. *Mutual companies* often are controlled by a few officers who have a working majority of votes by virtue of holding proxies from policyholders.

In addition to stock and mutual companies, there are in the business a few examples of what may be termed "mixed" companies. Such companies have characteristics of both stocks and mutuals, but in combinations that vary so widely that it is difficult to set up a general definition. For example, voting for directors may be shared between the stockholders and the policyholders. Sometimes voting by policyholders is restricted to those who own a certain minimum amount of insurance in the company; i.e., each stockholder may have a vote per share or a fraction of a vote per share, whereas any policyholder with some such minimum as \$5,000 of life insurance may have one

³ Some mutual companies make a proxy to an officer of the company a part of the application for insurance.

vote regardless of how much above the minimum he owns. In other cases the company may be technically stock but with a limit on profits to stockholders from participating issues; and the stock, or a large percentage of it, may be trusted.⁴

Stock Companies vs. Mutual Companies. Stock and mutual insurers may be compared and evaluated on the basis of several features.

Ease of Formation. One reason the majority of new life insurance companies are organized as stock companies is that statutory requirements for that type of insurer are more easily met than for a mutual insurer.⁵ For instance, under New York law a mutual company must have bona fide applications for insurance of not less than \$1,000 each from 1,000 people, with the full amount of one annual premium for an aggregate amount of \$25,000, plus an initial surplus of \$150,000 in cash. It takes an almost evangelical salesman to get people to buy and pay for life insurance in a company that does not yet exist. For a capital stock company, all that is necessary is a minimum of \$300,000 capital and \$150,000 surplus. Since the stock in well-conceived companies offers the possibility of both appreciation and investment income, it is less difficult to find the purchasers needed to provide the capital and surplus required. Once the stock has been subscribed and the state requirements (varying from state to state) have been met, the company can begin to solicit business as a "going concern."

Management. Advocates of stock companies contend that their officers, in response to pressures from stockholders for dividends, are likely to give more efficient management than will those who operate mutuals. This argument, however, is more theoretical than factual. The rank and file stockholder, like the rank and file mutual policyholder, rarely exercises his voting privilege in person, leaving actual control in the hands of the few who are actively concerned in the management of the company. It is also said that in a mutual company the executives have less incentive to be efficient in management since their only interest in the company is their salaries; yet examples of carefully managed mutual companies are to be found in plentiful number. On the other hand, the mere ownership of stock by management is not, per se, a guarantee of efficiency.

Actually, both mutual companies and stock companies are subject to good or bad management. Which they have at any time bears little relation to the fundamental nature of their organization. Good or bad management depends upon executives and not upon the type of company. A stock company may be and sometimes is run for the benefit of a few stockholders

⁴ It is common to refer to companies which issue both par and non-par as "mixed" companies. The authors do not feel that issuance of both types of policies justifies the classification of "mixed." Instead, there must be some mingling of stock and mutual characteristics in the basic structure of the company to justify the classification.

⁵ Often when a stock company is established and of fairly good size, it mutualizes. Some of the biggest mutual companies operating today were organized as stock companies.

alone. On the other hand, stock company management which puts the interest of policyholders above the interest of the controlling bloc is not unique.

Financial Stability. In judging the financial stability of a life insurance company, four factors must be considered: (1) investments, (2) reserves, (3) surplus, and (4) underwriting.

(1) INVESTMENTS. Since all legal reserve companies operate under the same investment laws, there seems to be no reason to assume that one type of legal reserve insurer makes safer investments than another. Any variations that exist among the investment portfolios of companies are based on differences in the investment philosophy and judgment of company management and not on type of organization.

(2) RESERVES. Minimum reserve requirements for all legal reserve companies are the same in any given state. Therefore, there is no inherent advantage or disadvantage in any one type of company as long as it is legal reserve.

(3) SURPLUS. Surplus, to be compared among companies, must be reduced to a percentage of obligations. A company with reserve obligations of \$20,000,000 and a surplus to policyholders (i.e., capital and surplus) of \$1,000,000 would not appear in as favorable position as a company with reserve obligations of \$10,000,000 and a surplus of \$750,000. In the first case, surplus is 5 per cent of obligations; in the second, it is $7\frac{1}{2}$ per cent. However, a small company to be equally safe would need a higher percentage of surplus than is needed by a large one because in a small company wide deviations of actual from expected mortality are more likely to occur. The greater the number of exposures, the less the uncertainty, and the less the need for relatively large surpluses.

Nothing is inherent in either type of organization that automatically assures it a larger surplus. This statement might be questioned by those who argue that the capital stock of a stock company offers an added margin of safety to policyholders. Except in the very small company, the capital stock is usually not a relatively large surplus factor. The important factor in appraising the surplus position of a company is not the ratio of capital stock to surplus but the ratio of surplus and capital to policy reserves and other liabilities. For example, take two very large life insurance companies, one a stock company, the other a mutual. The mutual has a ratio of 8.36 per cent of surplus to reserve liabilities, whereas the stock company has a ratio of only 6.97 per cent.⁶ Another mutual company has a ratio of only 4.67 per cent. In the stock company, the capital stock represents only slightly more than 10 per cent of the total surplus. A quick glance at any compendium of life insurance reports will reveal both stock and mutual companies with high and low ratios of surplus to reserve obligations. No pattern indicating a stronger surplus position for either type of carrier can be found.

⁶ This ratio includes capital stock and surplus to reserve liabilities.

(4) UNDERWRITING. Nothing appears in the structure of either type of company which adds any underwriting safety factor. While underwriting practices and philosophies vary from company to company, these variations do not stem from the ownership organization of the company.

Rates. Rate structures are a matter of the plan of insurance rather than of the type of company. Two rating plans are available, *participating* and *nonparticipating*. The participating rate is higher than the nonparticipating, but is adjusted periodically by the payment of annual (and occasionally extra) policy "dividends."⁷ Nonparticipating rates are not adjusted but remain flat throughout the premium-paying period. Stock companies can, and often do, issue participating policies. Mutual companies can, but rarely do, issue nonparticipating policies.⁸

Since participating premiums are loaded so that funds will be available to pay dividends, the first-year premium for a given amount of insurance on a nonparticipating plan is lower than that on a participating plan. For instance, in the rate book of one stock company issuing both participating and nonparticipating plans, the rates for continuous-premium whole life issued at age 25 are \$15.73 non-par and \$20.66 par. Thus a premium budget of \$250 a year will buy initially about \$15,900 of non-par insurance but only about \$12,000 of participating insurance.

The non-par rate remains less than the net participating rate (gross premium minus dividend) for a number of years. For example, the difference between the gross par rate and the non-par rate in the above company for the above plan is \$4.93. The present, but not guaranteed, dividend schedule for the participating continuous-premium whole life contract is as follows:

<i>Year</i>	<i>Dividend</i>		<i>Year</i>	<i>Dividend</i>
1	\$1.00		9	\$5.23
2	3.04		10	5.59
3	3.32		12	6.19
4	3.62		15	7.11
5	3.92		17	7.44
6	4.23		18	7.99
7	4.55		19	8.23
8	4.89		20	8.48

Not until the ninth year will the dividend under this scale be large enough to bring the net participating rate below the non-par rate. By that time the total excess paid on the participating contract will have accumulated to \$10.87, so that it will take eight more years until there is a net savings on this particular participating contract with this particular dividend scale. This illustration is not intended to leave an impression of exactitude. Comparisons

⁷ The policy "dividend" is not income in a mercantile sense, but a return of the unused portion of the premium; hence it does not have to be reported for income tax purposes.

⁸ Usually the stock company issuing participating plans also issues a line of non-par; and the mutual issuing non-par also issues par.

will certainly vary from company to company, plan to plan, and time to time.⁹

The participating rate of a prominent low-cost mutual company for continuous-premium whole life at age 25 is \$20.60. This is \$4.87 more than the nonparticipating rate of the above stock company. The present dividend scale of this company is more liberal so that the net premium on its policy is less than that of the non-par policy by the sixth year. The total of excess net premiums paid on the participating policy by that time equals only \$2.63, which will be more than recaptured by the tenth year. Another prominent mutual charges \$18.70 for its contract. Its present dividends are lower, but exceed the \$2.97 difference by the fifth year. By that time its contract has cost a total of \$1.96 more than the non-par contract, but by the eighth year this excess will have been more than wiped out. (Remember, these illustrations are based on present dividend scales, which are subject to change.)

An advantage claimed for nonparticipating insurance is the smaller amount of loading necessary for those expenses which vary directly with the premium. Since agents' commissions are based on gross premiums and the participating plan usually has the higher initial premium, the same rate of commission on the participating plan will produce a higher commission than it will on a nonparticipating plan. Another cost advantage of nonparticipating insurance is the absence of dividend payments. It costs money to calculate dividends, notify policyholders of the amount of them, and make out checks for those policyholders taking their dividends in cash. Since premium taxes are based on the gross rate minus the dividend, nonparticipating policies have no advantage in this respect.

Past dividend history on participating plans, as illustrated above, indicates that as a general rule the total premium paid for the non-par plan has been slightly higher.¹⁰ This has been a disadvantage, however, only to those non-par policyholders who live long enough to realize it. Those who die early have provided a higher amount of insurance for their beneficiaries than would have been available under a par contract carrying the same gross premium.

Advocates of participating insurance point out that a safety margin is available in participating rates. Insurers issuing participating policies charge a gross premium higher than they anticipate will be necessary, returning the excess as a policy "dividend." If mortality or investment experience is adverse, the premium overcharge is automatically available to offset it. Low interest yields, increased costs of administration, or adverse mortality experience may make it necessary for participating companies to cut the dividend rate on existing policies. Thus, increased costs in connection with business already on the books can be charged against that business instead of

⁹ A stock company issuing both participating and nonparticipating plans will usually make the two plans competitive.

¹⁰ This is speaking in averages, not company by company. Whether or not it will be true in the future depends on economic conditions.

being charged only against new policyholders, as is necessary with the non-par policies.¹¹ The participating feature, therefore, has the double-barreled advantage of (1) giving an added safety cushion and (2) assuring equity among all policyholders (new and old).

A theoretical advantage of participating insurance is that it offers insurance at actual cost, i.e., actual mortality cost plus actual cost of doing business. Competition within the industry is such, however, that the leading companies have to hold their rates in line whether they are participating or nonparticipating.

Another cost advantage of participating policies is the privilege of using the dividends to buy paid-up additions. However, whether this is a cost advantage of *value* to an individual policyholder depends upon how he uses his dividends.

One disadvantage inherent in participating insurance is that it too often leads to selling on a basis of projected net cost;¹² i.e., the agent leads the buyer to believe that the net cost of the proposed insurance over the policy period will be comparable to, if not identical with, the net cost computed either (1) over a period of past history (usually ten to twenty years) or (2) with the current dividend scale.

Few companies writing participating insurance can honestly deny that many of their agents sell on the basis of projected net cost. Of course, agents are asked to tell policyholders that projections of dividend scales are theoretical only and that nothing said should be implied as either guaranteeing or estimating that future cost experience will compare with the past. Also, accompanying all dividend illustrations is the statement that "dividend figures are illustrations only and neither imply nor guarantee future experience." Even so, the use of dividend illustrations as a sales point may lead to bad public relations. No matter how carefully the policyholder has been told that dividend projections do not imply future experience—and this is not too often carefully explained—the policyholder may well be resentful when he finds his premium after dividends greater over a period of years than the rates suggested as part of the inducement to buy.

2. FRATERNAL INSURERS.

The Uniform Fraternal Code of 1955, which has been adopted in full or in part by most states, defines a fraternal insurer as "any incorporated society, order or supreme lodge, without capital stock, conducted solely for the benefit of its members and their beneficiaries and not for profit, operated

¹¹ It will be recalled that one of the requisites of an insurable hazard is that it be possible to establish an equitable rate for it. Therefore, the claim that participating policies make for greater equity in rates is a specious one. However, whether equity of rates is a cost advantage depends upon whether or not it favors the side you are on.

¹² Net cost is defined as total premiums paid, minus dividends if any, minus cash value at the end of the period over which the estimate is being made.

on a lodge system with ritualistic form of work, having a representative form of government, and which makes provision for payment of benefits."

With the exception of the requirements for a lodge system with ritualistic form of work and for a representative form of government, a fraternal insurer appears to be the same as a mutual life insurance company: a corporation without capital stock, formed, organized, and carried on solely for the benefit of its members and of their beneficiaries and not for profit. Other differences, however, do exist as will soon become apparent.

Distinguishing Features of Fraternal Insurance. Several features distinguish fraternal insurers from "old line" insurers. The distinguishing features of the fraternal insurer are the lodge system, representative form of government, "open" contract, less stringent regulation, and tax-free status.

While the statutes require all members of fraternal benefit societies to belong to a local lodge of the society, often the lodge system of a fraternal is merely a token. This is particularly true of the fraternal which has reached a stage of development just short of "old line." At this stage, although only lodge "members" may be granted policies, anyone who wants to buy a policy can become a member automatically simply by purchasing the insurance.¹³ Currently, educational and charitable activities are more important to many fraternalists than the rituals of yesteryear.

In requiring that fraternalists have a representative form of government, the statutes prohibit voting by proxy.

Fraternalists are not allowed to issue "closed" contracts under which rates and policy provisions may not be changed. Instead, they must issue an "open" policy (called "certificate") in which the bylaws and rules of the organization are a part of the contract and any amendment to them is automatically an amendment to the policy as to rates and provisions. Also, upon impairment of the society's reserves, members may be required either to make an additional payment or accept a lien against their certificates.

State regulation of fraternalists generally is less strict than that applying to old line companies. Reserves, for example, may be computed on a less conservative basis than the Guertin legislation requires of old line insurers; i.e., fraternalists may use a combination of interest and mortality assumptions which yield lower reserves than the CSO table at 3½ per cent.¹⁴ Also, fraternal sales representatives in many states need not be licensed and in others are subject to less stringent licensing requirements. Regulation pertaining to investment is the same for fraternalists as for other insurers.¹⁵

¹³ Restrictions on membership, however, still prevail among typical fraternalists. Common restrictions are those limited to members of certain national, church, labor, and/or color groups. A few limit membership to men only and even fewer limit membership to women.

¹⁴ 3% in New York.

¹⁵ Since fraternalists are considered charitable institutions, they are exempt from taxation. They do not pay any federal income tax nor do they pay the state premium taxes.

Fraternal insurance plans originally were organized on the full assessment principle.¹⁶ As the average age of membership increased and assessments mounted, difficulties were encountered. Fraternalists soon recognized the importance of actuarially sound rate-making principles and began shifting to a legal reserve basis. When a fraternal has moved to a legal reserve basis, it may still continue to be a fraternal by virtue of holding on to its lodge system and its "social purpose." It is then known as a "legal reserve fraternal." When it has not only moved to a legal reserve basis but also has dropped its lodge system, as a few have done, it becomes an old line company. A "fraternal" always is a mutual. It may or may not be a pure assessment mutual. The usual metamorphosis of a successful fraternal is from an original assessment basis to a legal reserve basis (and in some cases, eventually, to an old line basis).

Advantages and Limitations. Although fraternalists are not required to maintain legal reserves as rigid as those required of old line insurers, many of them maintain their reserves on a basis every bit as conservative as the leading old line companies. Obviously, when fraternalists are not on a legal reserve basis, they may not have the same margins of safety as do the legal reserve insurers.

Fraternalists have an additional, theoretical safety advantage in the "open contracts" under which they reserve the right to increase the rates, levy an assessment, or modify the benefits of existing policies whenever such is essential to maintain solvency. Fraternalists never make a point of emphasizing this feature of their contract because buyers, as a rule, do not favor open contracts. Actually, the open contract in effect is not much different from the closed contract, since the closed contract can also be opened if reserves become deficient and company solvency is threatened. The courts can place a lien on policies of companies forced into receivership. The open contract of the fraternalists simply allows the society to do what the courts can force a legal reserve company to do.

When fraternalists are legal reserve companies, their surplus account may be similar to that of stocks and mutuals. However, many fraternalists not on a legal reserve basis report "surpluses" which, in reality, are not "surpluses" at all in the true meaning of the word. Instead, they represent future obligations to policyholders much as do the legal reserves in legal reserve companies, definitely a misleading use of the word "surplus."

Fraternalists have varying underwriting standards. Some fraternalists may be more lenient than some old line companies, whereas other fraternalists

(They do pay filing fees whenever they file required documents with the state.) Those fraternalists which actually do charitable and benevolent work are entitled to their tax-exempt status, but it is to be feared that a number of fraternalists are reaping the benefits of tax immunity without seriously performing any charitable or benevolent operations sufficient to justify their favored treatment.

¹⁶ Cf. Chapter 26.

may be more strict. The term "fraternal" does not in itself imply any particular underwriting standard—lenient or severe.

Fraternal life insurers are at neither an advantage nor disadvantage in rate comparisons for ordinary insurance. Just as among old line insurers, there is a clear variation in rates charged by the different fraternal life insurers. It would be possible to find some old line insurers which charge more and some which charge less than does any given fraternal selected at random. Fraternal life insurers in general, however, appear to offer insurance in low amounts (less than \$500) at more attractive rates than do the industrial departments of old line insurers.

About \$13 billion of fraternal life insurance is in force in the United States and Canada. Assets behind this insurance amount to over \$3 billion. Fraternal life insurers account for just slightly more than 2 per cent of all life insurance in force in the United States.

3. ASSESSMENT COMPANIES.

The assessment company may or may not be a fraternal; i.e., it may write insurance only upon "members" of some type of lodge or social system, or it may write policies for virtually the general public. For instance, one small Midwestern assessment company limits its policyholders interdenominationally to church members, a definite "class" limitation, but, at least in the United States, a broad class. The laws of many states now prohibit the incorporation of any new assessment associations.

The assessment life insurance company operates on the principle of practical as well as theoretical mutuality. In old line mutuals, the policyholder is paid a dividend which theoretically represents operating savings of the company. However, the policyholder does not share directly in an operating loss of an old line mutual. Policy dividends can be reduced or even eliminated if the company has made no savings to share; but there can never be a request for a higher premium. In the assessment company, the policyholder not only shares in the operating profit, through policy dividends, but also, in the event of loss, shares in that loss through an assessment—usually an additional premium.

The assessment mutual issues what is known as an "open-end contract." In effect, the insurer estimates the amount necessary for the operation of the business and the payment of claims during any premium-paying period and then establishes a premium rate in accordance with this estimate. It contracts with the policyholder to return any portion of that premium which is not required for operation. It also obligates the policyholder to pay additional premiums if they should become necessary.

A "legal reserve assessment company," sometimes called a "stipulated premium company," is one which maintains the reserve required by law but which retains a "contingency clause" in its policies in lieu of the required free surplus. Under this clause the company can call for additional premiums through assessment. In addition to the assessment feature, minimum rates

and reserves are required by state law. These organizations, therefore, are hybrids because they have characteristics both of assessment associations and legal reserve companies. In some states, Illinois for example, the new company is required to have the assessment clause in all contracts until the surplus reaches a certain minimum amount.

In theory, the assessment company should be the safest of all insurers because it is permitted under its contracts to charge an additional premium whenever the original rate proves inadequate for a given operating period. This advantage, however, is more theoretical than practical, because the task of collecting any sizable assessment is usually impossible.¹⁷ The assessment feature itself is usually considered to be a disadvantage by the insurance buyer, who generally shudders at the mentioning of the word "assessment."

Pass-the-Hat Assessment Companies. In addition to the assessment mutual, there are still in operation today some examples of purely "pass-the-hat" insurers. These are usually small racial, religious, or lodge organizations. Either they charge no premium in advance or charge only a small one designed to pay overhead costs. Each time a claim arises, members of the organization are requested to contribute an amount sufficient to pay the beneficiaries. These contributions generally are level among all members irrespective of age. Obviously, as members of the organization become older and the rate of mortality increases, the frequency of assessments will have to be increased on the remaining members or the benefit will have to be reduced. It has rarely been possible for a pass-the-hat organization to bring in the constant supply of new and younger members or contributors necessary to maintain financial health.

Currently, only about \$1.6 million of assessment insurance is in force in the United States—less than 0.3 per cent of all insurance in force in this country. These companies own about \$85,000,000 in assets.

4. SAVINGS BANK LIFE INSURANCE.

In recognition of the social and economic importance of insurance for the individual of modest income, it was suggested as early as 1874 that low-cost life insurance be written by savings banks. It was not, however, until after the Armstrong Investigation¹⁸ that such a proposal was seriously considered.

Two of the findings of the Armstrong Committee disturbed Louis D. Brandeis, the father of savings bank life insurance: (1) Many companies at that time seemed to put the interests of the policyholders last on the list of

¹⁷ A few instances can be cited of assessment carriers surviving an operating deficit or impairment of assets which would ruin an old line company. The safety margin of the assessment feature proved to be the saving factor in those cases.

¹⁸ An investigation by the State of New York, 1905, into many phases of life insurance company operations. Cf. Chapter 26.

considerations in the operation of the company. (2) The cost of weekly premium industrial insurance was comparatively high. So Brandeis, later Associate Justice of the United States Supreme Court, worked out a plan for the issuance of life insurance by the nonprofit mutual savings banks of Massachusetts. He convinced the legislature of the state that the banks would be a proper medium for the issuance of low-cost life insurance for the benefit of low-income groups. Originally, policies were to be limited in any one bank to \$500 upon the life of an individual. This limit subsequently was raised to \$5,000, although the insured can buy as many policies in different banks as he can get issued up to the statutory limitation of \$38,000.¹⁹ All the insurance, however, can be purchased through one bank. The originating bank serves as agents for the other banks. The \$5,000 limitation does not apply to group insurance. Annuities are limited to \$200 annual income per bank.²⁰

In 1907 Massachusetts passed the laws necessary to permit the banks to establish insurance departments and required that the funds of the insurance department be kept separate from the banking funds. The insurance funds are not available to pay any obligations which might arise in the banking departments, nor are the banking funds liable for any obligations of the insurance departments.

Originally, in order to establish an insurance department, it was necessary for a Massachusetts savings bank to obtain, by subscription, a guaranty fund. A later provision in the law required each bank operating an insurance department to pay into a central fund 4 per cent of the total premium it collected. The banks were required to continue to pay into this fund until it reached \$100,000, which amount was reached in 1921. The purpose of the arrangement was to provide the guaranty funds for additional banks wishing to establish insurance departments. The effect was to eliminate the burden on each bank of raising its own guaranty funds.²¹

In order to minimize the cost of savings bank insurance, the use of agents is forbidden. Further, in the beginning, the expenses of the office of

¹⁹ Although the statutory limitation is \$38,000, underwriting rules of the banks restrict the maximum coverage to \$35,000. Before July 24, 1951, the maximum limit available at any one bank was \$1,000. There are thirty-eight authorized banks in the system. When the maximum allowable in each bank was raised from \$1,000 to \$5,000 the total limit of \$38,000 was left unaltered.

²⁰ Although the statutory limitation on annual income from deferred or single-premium annuities is \$200 per bank or \$7,600 from all banks, underwriting rules of the banks restrict the total to \$1,800. The banks are free to set whatever maximum they wish as long as it is under the statutory maximum.

²¹ At the present time a Massachusetts bank voting to organize an insurance department must have as a cash advance to that department (1) a special expense guaranty fund of not less than \$5,000 to be applied in payment of expenses, and (2) a special insurance guaranty fund of not less than \$20,000 to assure the payment of claims. Under certain circumstances, in lieu of the special insurance guaranty fund, the General Insurance Guaranty Fund, with approval of the Commissioner of Insurance and the Commissioner of Banks, may contract to guarantee the risks of the insurance department of a savings bank until the bank's insurance department shall have accumulated a surplus of \$20,000.

actuary and medical director were borne by the state.²² The savings bank system in Massachusetts is supervised by the state insurance commission. A "Division of Savings Bank Life Insurance" of the Commonwealth's Department of Banking and Insurance employs "instructors" to present the insurance plan before employees and similar groups.

While the savings bank system does not use solicitors or agents, it does utilize, through the medium of a co-operatively supported Savings Bank Life Insurance Council, an extensive and continuous advertising and publicity program, employing all the usual advertising media—pamphlets, leaflets, radio, match folders, newspapers, etc.

Applications may be taken by nonissuing banks, employers, credit unions, and other types of authorized outlets, which may retain a small collection fee. Employers authorized to receive applications are not entitled to the collection fee.

The Division of Savings Bank Life Insurance assumes such functions as rate-making, underwriting and medical examinations. The individual banks have nothing to do with these operations. Through the medium of the General Insurance Guaranty Fund, mortality experience is pooled and distributed equally among the banks, thus creating a wider spread of exposures than would be possible for an individual bank to achieve in view of the fact that it cannot use agents, who actively solicit applicants and thus increase the spread of risk.

All savings bank life insurance is issued on a participating basis. Types of policies and policy provisions are those customarily found in the commercial companies. A popular plan for premium payment is to have the bank authorized to pay premiums regularly from savings accounts.

The growth of business in force among the savings banks in Massachusetts was slow in the early years. Originally, banks were not enthusiastic about the plan. Up to 1922 only four banks had established insurance departments. Since that time, however, many new departments have been added, and the volume of business in force has grown substantially.

Legislation to permit the establishment of savings bank life insurance in the State of New York was passed in 1938 and in the State of Connecticut in 1941.

The requirements for the establishment of a separate insurance depart-

²² Through the years 1907–1926 all expenses of the Massachusetts Savings Bank Life Insurance Division were borne by the state. During 1927–1933 an increasing portion was reimbursed to the state. For the period 1907–1933 the following figures relate to the expenses of the Division: total actual expenditure, \$670,248.43. Reimbursements to the state by banks from 1927 through 1933 were made in the amount of \$119,102.21, leaving a net state expenditure of \$551,146.22. Since 1934 there have been no out-of-pocket expense subsidies. From 1934 to 1938 the banks have reimbursed the state at the end of each year for the actual amount spent. From 1939 to the present banks have been paying into the State $\frac{1}{12}$ of the annual appropriation each month in advance. The Massachusetts Savings Bank Life Insurance Division is still housed, rent free, in the State House.

ment by New York mutual savings banks are much the same as those for Massachusetts banks with some technical exceptions.²³ In New York, as in Massachusetts, savings banks have the same rights in general and are subject to the same limitations in their insurance operations that apply to other domestic legal reserve life insurance companies. The amount of insurance that may be written, however, is limited to \$10,000 plus \$20,000 of decreasing term insurance. Insurance may be written only for residents or people regularly working in New York.

Like the Massachusetts banks, New York savings banks write all the regular forms of life insurance. Individual annuities are not written. About forty-eight banks have insurance departments.²⁴

Similar regulations exist for the formation and operation of an insurance department in a Connecticut mutual savings bank.²⁵ Thirteen banks in Connecticut are qualified to issue insurance. The banks issue the usual line of policies. The maximum amount of insurance that may be purchased on the life on one individual is \$5,000—whether purchased all in one bank or divided among several banks.

The extension of the system of savings bank insurance into other states has been advocated from time to time, and bills authorizing savings bank insurance have been introduced in several state legislatures without success.

Commercial carriers and agents have charged savings bank life insurance with unfair competition, citing initial subsidies and favorable regulatory treatment, especially in Massachusetts. Savings banks seek to dismiss

²³ To establish an insurance department, a New York mutual savings bank must (1) establish a surplus fund of not less than \$20,000 to meet operating expenses and losses occasioned by other causes and (2) invest \$5,000 (formerly \$20,000) in the Savings Bank Life Insurance Fund.

²⁴ The New York Savings Bank Life Insurance Fund, which is outside of the New York insurance department, administers the unification of mortality among the banks, determines premiums and policy forms, and prescribes underwriting rules and regulations. In general, the fund provides the services of the actuary and medical director. The fund is financed entirely by the issuing banks which, in addition to their original investments of \$5,000, may be required to pay into the fund a given percentage of premiums received. The percentage has fluctuated between 1 per cent and 4 per cent (now 1 per cent). The approval of the Superintendent of Banks is required for any change of this percentage.

²⁵ Here again are technical exceptions. The Connecticut statutes state that a mutual savings bank may establish a life insurance department by advancing a surplus fund of at least \$5,000 to the insurance department of the bank and the investment in the Savings Bank Life Insurance Fund of not less than \$1,000 for each \$1,000,000 or fraction thereof of the book value of the bank's assets, but not to exceed \$50,000. No investment will be required in the Savings Bank Life Insurance Fund when the assets equal or exceed \$100,000. Assets of the savings department of a bank and of the life insurance department shall be separate. At the end of each year the ratio of actual to expected mortality for all the savings and insurance banks combined and for each separately is determined and an adjustment is made accordingly by the Savings Bank Life Insurance Fund. Expenses of the fund are apportioned among all the issuing banks. Banks are required to pay monthly to the Savings Bank Life Insurance Fund an amount not to exceed 4 per cent of all amounts paid to them as premiums or in the purchase of annuities during the preceding calendar month.

these objections as attempts of companies and their agents to protect their market.

Advantages and Disadvantages. The saving banks offer a financially solvent plan. Savings banks operating insurance departments must invest insurance funds in the same way they invest banking funds, except they may make policy loans. Savings bank investments are more restricted than the investments of commercial life insurance companies.

Legal reserves required of savings bank insurance are the same as those required of private commercial insurers.

As for surplus, the laws of the various states differ for savings bank life insurance. In Massachusetts, for example, each bank must accumulate a minimum surplus of \$20,000 out of its profits. After the minimum is obtained, the bank must pay out in dividends 85 per cent of profits. Unless the state actuary approves a higher figure, the maximum surplus which a bank may hold is 10 per cent of its reserve. Additional protection is provided in the bank's pro rata share of the assets held by the General Insurance Guaranty Fund. Without taking into consideration the General Insurance Guaranty Fund, the average surplus today for all banks is more than 9 per cent of total liabilities. This is in excess of that of many mutual and stock companies.

As to underwriting, under the "unification of mortality" system, banks showing better than the average mortality experience for all banks pay into the General Insurance Guaranty Fund an amount determined by the actuary of the state. The banks experiencing higher-than-average mortality receive such contributions. However, since the underwriting is done centrally for all the individual banks, mortality experience is as uniform as the underwriting can make it. The pooling of mortality experience is not a matter of underwriting safety but is designed to iron out the expected fluctuations in mortality experience of the banks with a small volume of insurance. Although the mortality experience among savings banks is good, it can be matched by some of the well-managed stock and mutual companies.

Savings bank life insurance usually is offered at lower premiums, and its net cost generally has been lower than that of the typical commercial legal reserve company.²⁶ One factor contributing to lower rates is lower overhead charges. The banks provide the housing and clerical staff to the insurance fund. For accounting purposes, a proportionate amount of the total overhead of the bank is chargeable to the life insurance department; nevertheless, the cost of two families living under one roof usually is not exactly double the cost of one family living alone under that roof. Also, actuarial and medical service is centralized in a co-operative bureau.

Savings banks claim they can offer life insurance at lower rates also

²⁶ The rates for savings bank life insurance are probably not as much lower than those for regular carriers as Brandeis expected they would be. There are several regular companies currently issuing policies at rates, dividends, and cash values that compare favorably with those of the savings banks.

because they pay no salesmen's commissions.²⁷ Consequently, loading for the servicing of savings bank life insurance policies is less than that for the servicing of regular life insurance policies. Finally, costs are lower because of a low lapse rate. The lapse rate for savings bank life insurance is currently about 2 per cent a year, whereas the lapse rate for the industry generally is now running over 5 per cent. Since most of the savings banks' policyholders are those with sufficient sense of responsibility to buy on their own initiative, they are not likely to lapse their policies.²⁸

Since savings bank insurance operates without agents, it cannot offer as much service to policyholders as can the typical insurance company. It is true that savings bank outlets are well scattered throughout the three states, but the difference in service between savings bank insurance without agents and companies with agents is the same as the difference between the physician who won't make house calls and the one who will.

Savings bank life insurance accounts for well over \$1,000,000,000 of insurance in force, but represents only about 1.4 per cent of all life insurance in force in the three states in which it is written.

5. GOVERNMENT INSURERS.

Both the state and federal governments act as insurers in the life and health fields. It is argued in some quarters that the government should not compete with private enterprise so long as private business is interested and able to provide the service at a reasonable price. Those who defend government insurers point out that, for the most part, these insurers provide insurance that is required by law as a part of a broad system of social reform, and that they have been established by democratic procedure. Social insurance, they claim, is a proper state service.

State Insurers. For life insurance, only one state fund exists—the State (Life) Fund of Wisconsin. In health insurance, four state funds are operated under the Temporary Disability Insurance laws and eighteen under the workmen's compensation insurance laws.

The Wisconsin State (Life) Fund. The Wisconsin State (Life) Fund is a life insurer controlled and operated by the State of Wisconsin.

The legislature of the State of Wisconsin in 1911 authorized the Commissioner of Insurance to issue life insurance on residents of the state. The first policy was issued in October, 1913.

The maximum amount of insurance which may be issued by the fund on

²⁷ There is, however, a sales cost factor in the loading for the rates for savings bank life insurance to pay the cost of advertising

²⁸ If these were the only people who ever bought life insurance, there would be far fewer American families with insurance protection. The agent induces many to provide needed protection who would never buy on their own initiative. More of these "sold" policies lapse than among the self-selected, but many of those who do stick are people SBLI would never have covered.

one life is \$5,000 and the minimum \$500. Only Wisconsin residents are eligible for insurance. Annuities and group insurance are not issued.

The state assumes no liability other than through the fund itself. Administration of the fund is by the state treasurer. The conduct of the business is left to the state insurance commissioner. The state board of health assists in medical selection, and the treasurer of the state is the treasurer of the fund. The secretary of state audits the accounts submitted to him by the audit board, members of which also are state officials.²⁹ Applications are taken by designated state, county, and city officials, and state banks, and through them are forwarded to the commissioner.

The fund invests conservatively, with over 90 per cent of its assets in bonds. Reserves are computed on a conservative basis, American Experience at 3 per cent. Its surplus position is strong.³⁰

Rates are relatively low because the fund pays no office expenses or rent, and no part of the salaries of the state officers who administer the fund is charged against the fund. Service is reduced to a minimum. No agents are employed, no advertising is used, no settlement options are given, and the lapse ratio generally is less than 1 per cent.

The Wisconsin Life Fund has nearly \$7,000,000 of insurance in force, which represents less than 0.07 per cent of all insurance in force in that state.

State Disability and Workmen's Compensation Insurance Funds. California, New Jersey, New York, and Rhode Island operate funds to insure employer obligations under the Temporary Disability Insurance laws of those states. In Rhode Island the fund is monopolistic, whereas in the other three states the fund is competitive; i.e., employers have the option of insuring with regular insurers upon meeting certain conditions. Eleven states³¹ operate competitive funds to insure employer obligations under workmen's compensation laws, and seven states³² plus Puerto Rico operate monopolistic funds.

The Temporary Disability Insurance laws are designed to offer the employee partial protection against loss of income in event of nonoccupational accidents and illnesses. The workmen's compensation laws offer partial protection against occupational disabilities. These laws vary among the states.³³

²⁹ The attorney general, state treasurer, and commissioner of insurance.

³⁰ Not less than 10 per cent of the net profits for each year shall be contributed to surplus. Such contributions shall be sufficient to maintain a ratio of surplus to admitted assets of not less than 7 per cent, and may be discontinued in event such ratio exceeds 15 per cent.

³¹ Arizona, California, Colorado, Idaho, Maryland, Michigan, Montana, New York, Oklahoma, Pennsylvania, and Utah.

³² Nevada, North Dakota, Ohio, Oregon, Washington, West Virginia, Wyoming.

³³ For an excellent summary of the Temporary Disability laws, see United States Department of Labor, Bureau of Employment Security, *Comparison of Temporary Disability Insurance Laws*, December, 1958. This material is presented in tabular form for easy reference. For a summary of the state workmen's compensation laws, see United States Department of Labor, Bureau of Labor Standards, *State Workmen's Compensation Laws*, Bulletin 161 (revised), August, 1957.

Federal Insurers. The federal government offers life and health insurance through several agencies. Each of these agencies will be briefly mentioned.

The Veterans' Administration. Over \$43 billion of life insurance is in force on the lives of veterans of the armed services. The majority of this amount (over \$35 billion) is participating National Service Life Insurance (NSLI) issued during and after World War II; about \$6.5 billion is non-participating National Service Life Insurance issued since 1951 under the Servicemen's Indemnity Act; and about \$1.5 billion is United States Government Life Insurance (USGLI) on the lives of veterans of World War I.

USGLI. War Risk Life Insurance was established as a war measure in World War I to cover disability or loss of life among members of the armed forces engaged in warfare, because the military hazard during wartime on new applicants is considered uninsurable by private companies. Policies originally issued were on a one-year term basis (renewable for only five years) with the rate increasing each year. Subsequent extensions of time, however, were granted. In 1919 the term policies were made convertible to permanent forms; in 1924 the coverage was made available to all members of the armed forces; and in 1928 the insurance was made available to veterans of World War I who met certain eligibility standards.³⁴ The policies issued under these amendments make up what is known as USGLI.

United States Government Insurance is legal reserve life insurance issued on a participating basis and is backed by a trust fund set up from premiums collected and held in the Treasury Department, administered by the government as trustee. All costs of administration as well as claims resulting from the extra hazard of military or naval service are paid out of the general tax fund and not funds created by premiums paid in. The provisions of the policies are generally similar to those written by insurance companies, with but few exceptions.³⁵

Disability income benefits are also available with USGLI.

NSLI. National Service Life Insurance was created by act of Congress in 1940. The NSLI system provided policies for persons on active duty with the military and naval forces, including the Coast Guard. It was voluntary and available to those in active service. No evidence of insurability was required if application for the insurance was made within 120 days after entrance into the service. Policies were issued on a five-year, level-premium term plan on a participating basis, convertible on any premium date to continuous-premium whole-life, twenty-pay life, thirty-pay life, twenty-year endowment, endowment at age 60, and endowment at 65.

³⁴ Sale of new USGLI to veterans was discontinued in 1951. Its sale to members of the armed forces was discontinued in 1940, with the birth of National Service Life Insurance.

³⁵ The policy is nonassignable within certain limits; irrevocable beneficiary designations are not allowed; cash values may not be applied under settlement options; the policy is incontestable from date of issue; and death inflicted as a lawful punishment for a crime is excluded.

As in USGLI, the policy provisions are similar to those of regular company contracts with the same exceptions.

In addition to the free waiver-of-premium disability provision, National Service Life Insurance policies include a total disability income provision of \$10 a month per \$1,000 of insurance for an additional premium.

In National Service Life Insurance, all costs of administration, the cost of excess mortality as a result of the extra hazard of military service,³⁶ and the cost of waiver of premium on account of total disability traceable to extra hazards of military or naval service, are borne by the general tax funds. The maximum amount of NSLI any one individual may own (including any United States Government Life Insurance he may have) is \$10,000. The insurance is backed by a trust fund held by the Treasury, similar to the fund back of United States Government Life Insurance.

NSLI settlement options are particularly advantageous to the beneficiary in comparison to typical settlement options of commercial carriers. National Service Life Insurance pays the same benefits to women as to men and assumes a more favorable interest return and mortality experience than do most commercial companies;³⁷ so if National Service Life Insurance is used to provide installment payments rather than a lump sum, it has an additional cost advantage.

Paralleling the history of World War I insurance, National Service Life Insurance has been dropped by policyholders at a startling rate.³⁸

SERVICEMEN'S INDEMNITY. Issuance of new NSLI policies to servicemen was terminated³⁹ by creation of the servicemen's gratuity system in 1951.

Gratuitous death benefits for members of the armed forces were established partly as a result of public pressure against what critics termed the "government in the life insurance business," and partly as a result of studies showing that it is actually cheaper for the government to provide free in-

³⁶ This includes death at any time after separation from service if evidence indicates the death was contributed to by service.

³⁷ American Experience, 3 per cent.

³⁸ The relatively slow progress of savings bank life insurance, the slow progress of the Wisconsin State Fund, and the tremendous decline of both war risk insurance and National Service Life Insurance would seem sufficient evidence to justify the conclusion that in spite of low cost, life insurance either cannot be sold in volume or will not remain in force unless the sale of it is actively solicited and the business constantly resold. The expense of constant solicitation and continuous reselling would, of course, destroy much of the cost advantage which now exists for savings bank, Wisconsin State Fund, and National Service Life Insurance.

³⁹ Except that within 120 days following separation from service, a veteran could apply for a five-year renewable term policy, non-par, at attained age. Effective January, 1959, these five-year renewable term plans were made convertible to a non-par permanent plan or to a non-par convertible term plan renewable to age 50. The disability income rider (\$10 a month per \$1,000) was also made available in 1959 for this new non-par NSLI. A veteran who had a service-connected disability could apply for non-par NSLI on one of the regular whole life or endowment plans available, if the application was filed within one year after the disability was determined by the VA to be service-connected. Premiums are waived if the disability is or becomes total.

demnity than to finance the administrative machinery necessary to collect premiums, account for them, and then return a large part of them in dividends. The cost of administration of NSLI were greater than the net premiums retained.

Under the indemnity system each serviceman was automatically covered for \$10,000 without any payment of premiums. Benefits were payable in 120 monthly installments of \$92.90. Eligible beneficiaries were restricted. If there were no eligible beneficiaries, no benefits were payable. The money could not be paid to the estate of the deceased.

THE SERVICEMEN'S AND VETERANS' SURVIVOR BENEFITS ACT. The issuance of NSLI to veterans was terminated on December 31, 1956, for all except veterans with service-connected disabilities, with the passage of the Servicemen's and Veterans' Survivor Benefits Act. Disabled veterans are still allowed to purchase any regular form of non-par NSLI within one year after the disability is certified as service-connected by the Veterans' Administration. The Servicemen's and Veterans' Survivorship Benefits Act brought members of the armed forces under the Federal Old Age, Survivors', and Disability ("Social Security") system on the same basis as any other covered employee with one exception: a service member who dies without having earned a fully and currently insured status will be deemed to have that status for purposes of survivorship benefits.

The Department of Health, Education and Welfare. The only compulsory insurance in the field of life insurance is Social Security. It might be contended that Social Security is not insurance. Rates and values are not a matter of contract between the insured and the insurer but are set by legislation, which has been and will be changed frequently. Social Security benefits are not mathematically based on premiums collected.⁴⁰ However, for all practical purposes, at least certain benefits under Social Security bear a close enough resemblance to insurance to justify their classification as social insurance.

Three types of life insurance benefits are available under Social Security. (1) retirement income benefits, (2) lump sum death benefits, and (3) income benefits for certain classes of survivors. In addition, disability income benefits are provided. These benefits are important enough in the financial plans of the typical policyholder to be given special consideration by life and health underwriters in the programming of income insurance. However, because benefit structures and eligibility requirements change so frequently, it is better to obtain details from sources which can be kept up to date more readily and efficiently than a textbook.⁴¹

⁴⁰ Some economists feel that it would be sounder economically to pay all benefits from general taxation. They argue that nothing is to be gained by funding the benefits, either partially, as is now done, or fully, as is sometimes proposed. A funded Social Security system can hamstring the government in its efforts to promote economic stability through its fiscal policy. These economists, however, do recognize the psychological problems involved in eliminating the contributory feature from Social Security.

⁴¹ Current information on Social Security eligibility requirements, tax rates, and

Other Federal Insurers. The federal government has become an insurer under the Railroad Retirement Act and the Civil Service Retirement Act. Under these programs retirement, disability, and survivorship benefits somewhat like those provided under Social Security are made available to highly restricted classes of employees. For work-connected injuries of federal employees, the federal government serves as an insurer under the Federal Employees' Compensation Act.

6. DIFFERENCES AMONG INSURERS OF THE SAME TYPE.

From the buyer's standpoint, more important differences result from company philosophy and practices than as a result of type of organization. Significant variations exist among mutuals, stocks, and fraternalists themselves.

Acceptability of Applicants. Not all companies accept the same classes of business. Some companies, regardless of whether stock or mutual, will accept juvenile applicants.⁴² Others do not. Some companies, in order to restrict themselves to more favorable mortality groups and hence offer lower rates, will write only a certain type of applicant; for example, teachers, in the case of the Teachers' Insurance and Annuity Association; or ministers, certain church officials, and their families only, as in the case of the Presbyterian Ministers' Fund.

Some variations in type of acceptable applicant do exist, however, as the result of the nature of the insurer. These are particularly variations among fraternal insurers. For instance, fraternalists, because of their basic structure, write members only. They may further vary by imposing membership qualifications along religious, national, or occupational lines.

Differences in Policies Issued. Companies also vary as to types of policies offered. In the main, every commercial company offers a continuous-premium whole life policy or a policy paid up at 85. They also offer at least one or two limited-payment policies, several endowments, and one or two forms of term.

Combinations and variations of the "standard" policy forms differ widely, as we have seen. Some of these differences are a result of differences in underwriting philosophy. Policy forms that one company considers sound another may not. Another reason for the differences is varying investment practices; one company may be more interested than another in bringing in investable funds; consequently, one company will stress policies with a high savings feature, whereas another will stress those with a low savings feature.

Perhaps the greatest source of variation among types of policies offered

benefit formulas can be obtained from any local Social Security office. It also can be found in any of a number of standard reference works on life insurance, for example, National Underwriter's *Diamond Life Bulletins*, *Unique Manual*, *Little Gem*; *Flitcraft's*, or Research and Review Service's *Advanced Underwriting Service*.

⁴² Ages 0 to approximately 10. The age at which applicants will be considered for adult policies varies from company to company.

Types and Analysis of Life Insurers

is competition. Small and less widely known companies (and sometimes even the large and prominent companies) design special policy forms to offer in competition with the standard policies of their competitors. From the viewpoint of some companies the special policy form also has the advantage of not being comparable to the policies of other companies, thus eliminating cost comparisons.⁴³

Variations in Contract Provisions. In life insurance there are no “standard” policy forms. This statement is true despite the fact that the term “standard” is used to designate a certain group of policies which generally bear the same name among all companies and are alike in their major provisions. Rarely, however, are two life insurance policy contracts identical. A clause here or a clause there, even a phrase here or a phrase there, could make a difference in the value of the coverage at some future time. However, since no one knows at any given time what the future will bring, one’s interpretation of what clause will prove of most value is in direct proportion to his ability to foresee the future.

In general, nevertheless, it is possible for the buyer to decide what clauses, phrases, and provisions of a policy are most needed in view of the major purpose for which he purchases the policy, i.e., for instance, whether he purchases it for retirement value, estate clearance fund, or income to his family in case of his death.

Perhaps the greatest variation among policies, even among those by the same name, is in optional modes of settlement. Options vary not only as to guaranteed amounts per installment, but also in nature.⁴⁴ For example, not all companies include the joint and survivor options. Some contracts contain life income options based on five-, ten-, twenty-, and twenty-five-year-certain periods, whereas others limit the period certain to ten and twenty years. Some include life income—no refund.

The options written in a life insurance contract at the time of its issuance usually are not the only ones which the companies will write. Almost all companies will write special settlement options upon the request of the policyholder and will attach the agreement to the policy as part of the contract. Many also will make special settlement agreements with the beneficiary. However, it should be remembered that the only options the company is obligated to grant are those which are either written in the policy or attached

⁴³ Because of these variations in types of policies offered, it often becomes necessary for the buyer to look beyond one company to find a policy form best suited to his needs. The competitive special policies sometimes fit a particular life insurance need better than the “standard” form mentioned. *Who Writes What*, an annual publication of the National Underwriter Co., 420 E 4th Street, Cincinnati 4, Ohio, is an excellent guide to companies by type of policy issued. It attempts no ratings or recommendations, confining itself to a listing of companies by policies. For an explanation of the provisions of these policies, it is necessary to seek the services of a qualified life insurance agent.

⁴⁴ Guaranteed amounts per installment vary among companies as a result of differing mortality and interest assumptions.

thereto as a part of the policy. Other options are issued according to "company practice," and company practice may vary from time to time. Moreover, there is a difference among companies in liberality in drawing up settlement agreements. Some companies will write virtually any type of legal settlement agreement requested. Others adhere to more or less standard forms.⁴⁵

The differences mentioned in company practice in writing special settlement options carry over into variations in other matters as well. For instance, there is a variation among companies regarding the automatic premium loan. Some companies include it as a regular provision of the policy. Others include it only on request. Others will not write it at all. There is likewise a variation among the practices of companies in writing a "spendthrift" trust agreement.⁴⁶

Special settlement agreements, spendthrift clauses, and the rest represent trustee functions. The differences noted in company practices relating to them stem largely from differences in management philosophy among companies as to the extent the company feels it should engage in operations it may deem more suitable for a trust. Management thinking is not agreed on the line of demarcation between the life insurance and trust businesses.

Other contract provisions which are likely to vary among companies are those relating to disability benefits, loan and surrender values, change of plan, dividend options, reinstatement, incontestability, and double indemnity.

Variations in Costs. Variations among companies as to cost of a policy always arouse the most interest among laymen, the greatest amount of discussion by "insurance advisors," and too much of many a sales presentation. Actually, in many case it is almost impossible to determine what the differences in cost between policies and companies will be. The impossibility arises from the fact that no two policies ever are exactly alike. The policyholder, unable to predict the future, cannot determine which policy, in the final analysis, will offer him the most for his money.

Companies not using agents offer insurance at lower rates. The difference in rates is to a large extent the agent's commission. The agent's service to the policyholder, and especially to the beneficiary, can have a definite value in money. Whether the service is worth the difference in premiums depends upon the kind and extent of service needed and rendered both to the insured and his beneficiary—something which, again, cannot be determined absolutely when the policy is purchased.⁴⁷

⁴⁵ For a good compendium of variations among settlement options and company practices relating to them, see the annual publication of the Flitcraft Company, *Settlement Options*.

⁴⁶ Under which the beneficiary is prohibited from invading the principal at all or for more than a set amount in addition to the installments elected, and the creditors of the beneficiary are prohibited from attaching the principal while it is in the hands of the insurance company.

⁴⁷ It should be pointed out that cost is not always related to service. The fact that there is loading in the premium rate to take care of service to the policyholder does not

The cost of a policy may depend also on its use. A company issuing a policy with a somewhat higher per-thousand premium rate may have in that policy more favorable settlement options than a company issuing an almost identical policy at a lower per-thousand premium rate. Which is the more expensive policy will depend upon whether the policyholder eventually uses it to provide a lump sum benefit (in which case the policy with the lower rate has cost him less) or for a periodic income (in which case the policy with the higher rate may actually cost him less).

The cost of a policy may also depend on what is often referred to as the net cost, i.e., total premiums paid, minus dividends if any, minus the amount collected upon surrender of the contract.

Unfortunately, there has developed the aforementioned practice of selling on an illustrative projected (or historical) net cost basis. "Net cost" selling is not only misleading but is also invalid in determining the actual cost of a life insurance policy. It assumes that the policy is discontinued at some given point, the ultimate period of years used in the illustration.⁴⁸ Unless, therefore, the policy is cashed in at that time, the net cost will be other than what is shown in the illustration. If the policy is surrendered, then the protection, the major purpose involved in purchasing the life insurance, is also discontinued. For this reason, net cost projections are sometimes called "surrendered net cost." For the policyholder who continues his insurance in force until death, net payments (premiums minus dividends) are the proper measure of cost, and this will not be known until the maturity date of the contract is known.

Net cost illustrations are fallacious. For instance, if carried for enough years, they often show that life insurance can be purchased free. These net cost illustrations eliminate the whole question of interest and survivorship benefits. If interest on premium deposits and survivorship benefits were considered in net cost illustrations, the picture would be entirely different.⁴⁹ In the way net cost figures currently are presented, it might be possible to find a high net cost for a company charging a low rate or a low net cost for a company charging a high rate. In fact, it would be possible for an insurance company to charge a high enough premium so that interest earnings and survivorship benefits themselves could pay the cost of insurance right from the start. For this reason, net payments must be considered carefully in judging any net cost projection.

Finally, net cost selling often induces policyholders to purchase in-

always mean that the policyholder will receive that service. While this difference depends largely on the capability and sincerity of the agent with whom the policyholder deals, it is also related to some extent to the philosophy of the company. Once again, a good agent may render service of value over and beyond the loading factor in the premium—and so may his company. Another agent or company may not render service of value equivalent to the loading factor.

⁴⁸ Net cost illustrations published in life insurance compendiums usually are based on 10- and 20-year periods.

⁴⁹ Interest and survivorship benefits are covered in Chapter 1.

surance on a "cost" basis alone, which may ultimately prove to be the poorest possible basis for buying; and it paves the way for borderline companies to write a startlingly low-rate policy by restricting benefits. To say that one policy is "overpriced" whereas another is "correctly priced" on the basis of the premium rate alone is equivalent to stating that one make of car is overpriced simply because it costs more than another make. It may be that the more expensive car is overpriced; again, it may be that for value received, its price is less than that of the cheaper car.

Variations in Underwriting Practices. So many variations exist among companies in underwriting practices that it is difficult to cite representative examples. One company may accept a health condition that another would not accept. Again, some companies write insurance only on standard lives, while others accept substandard lives. Even among those who write substandard business, there is a variation as to how far a company will go in this direction. Some companies will write disability income protection in connection with life insurance, some will attach riders agreeing to waive future premiums in case of permanent and total disability, some will attach double indemnity riders under which the face amount of the policy will be doubled in case of death by accidental means; some will write one or another of these riders; and some will write none at all. Some companies will write pension trust and group insurance, and some will not. Differences exist among companies as to what are considered hazardous occupations and subject to an extra rate or not acceptable at all. The well informed life insurance agent knows which company is most apt to accept any given type of case.

Variations in Investment Practice. Variations in underwriting practice are equaled by variations in investment practice. The insurance code of each state limits the types of securities in which a life insurance company may invest funds; but within the limit of the law it is possible for practice to vary widely. For instance, some companies will invest more heavily in real estate mortgages than will others. Even among those who invest heavily in mortgages, there may be variation as to type of mortgage, some leaning more to the monthly repayment residential mortgage, while others prefer lump sum repayment commercial property mortgages. Others like farm mortgage investments. Some companies invest more in United States Government securities; others buy more heavily the securities of business and industry. Some are more interested in common stocks than are others, although the total of assets that can be put into common stocks is limited by state laws.

Variations in investment philosophy and practices arise out of differences of opinion among competent investment men as to future earnings and investment trends of the whole investment field. Investments are a specialized study, requiring a high degree of knowledge and skill. Investment practice, unlike mortality, is not subject to mathematical formulas. It is impossible to say today which investment will turn out to be best in the future. Investment

men can only apply their knowledge and understanding to deciding individually which security has the best outlook at the moment.

Certain types of investment are universally recognized as "risk" investments—important in the creation and expansion of business and industry, but unsuitable for the "trust" investment purposes of life insurance companies. The cardinal principle of life insurance investing is security. Earning is second. Variations in investment practices affect interest earnings and consequently influence the cost of insurance in any given company. However, it is impossible to select with accuracy the "lower cost" companies of the future on the basis of an analysis of today's investment portfolios. Differences of opinion will be found among the most astute investment men.

Variations in Size, Surplus, and Reserves. Perhaps the most noticeable variation among life insurance companies is that of size. They run the gamut from companies with a few *millions* in force to companies with many *billions* in force. Not only do companies vary in size according to the amount of insurance in force but also according to assets.

Contingency reserves and surpluses also vary among companies, for the most part as a result of different actuarial philosophies. The actuaries of one company may be able to marshal irrefutable arguments and mathematical formulas to prove the adequacy of the size of their contingency reserves and surpluses, whereas those of another company of almost exactly the same size will be able to marshal equally irrefutable arguments and formulas to prove that a contingency reserve of a different size is correct. Mathematics go so far; human judgment must then enter.

Differences in reserves depend upon the system adopted for their calculation. State laws set up minimum reserve standards. Companies may use higher standards than the minimum, and many do. The old and established companies usually use formulas yielding higher reserves than those used by the new companies which may lack the necessary surplus to establish higher reserves.

7. FACTORS TO CONSIDER IN THE SELECTION OF A COMPANY.

Most of the factors which should be considered in selecting a company from which to purchase insurance already have been implied. This concluding section of the chapter, therefore, is actually little more than a summation.

The Factor of Service. In selection of both company and agent, the buyer should consider the matter of service. In the case of companies, variations are a matter of management philosophy rather than type of insurer. Some companies are more bound by red tape, which can retard service. Others so restrict the authority of agencies that matters that might be handled locally must make the long trip to the home office. Wide variation in company flexibility in the handling of special settlement agreements essential to program-

ming and estate planning is apparent. There is an even greater variation in service rendered by agents. The amount and adequacy of service from any agent depend largely on his ability and desire to serve.

The Type of Policy. It is necessary for a buyer to limit the selection of a company to that company offering the types of policies which fit his particular insurable needs. Too often the need is fitted to the policy rather than the policy to the need. For instance, the need calling for a family income policy may be improperly fitted with a family maintenance policy; or the need for yearly-renewable term may be improperly met by the use of a ten-year renewable term policy. These are but two obvious examples. Usually, there is no reason to compromise a need simply because a given company does not write the policy that exactly fits that need. The chances are that another equally good company does write it.

The Factor of Cost. It should be repeated that price buying is not only dangerous but also can be disastrous. While differences in cost do exist, they are difficult to ascertain and determine. Emphasis on cost or price buying inevitably results in judging cost by the only apparently variable factor: the premium rate. The fact that one premium rate is lower than another does not mean necessarily that in the end, the low-rate policy costs less than any other.

In some instances variations in cost among insurers is clear. National Service Life Insurance, subsidized by tax funds, savings bank life insurance, and the Wisconsin Life Fund have certain cost advantages which may or may not be offset by their inability to render the same service as life insurance companies. Some buyers of insurance do not feel the need for the services of agents.

It should be pointed out that a policy purchased on a basis of price alone can prove, in the end, to be expensive. The primary consideration is whether or not the buyer understands his need and whether or not the insurer has available the type of policy needed. The policy that best fits the need will prove to be the cheapest policy in the end, even if the rate is somewhat higher than that for another policy not exactly suited to the need.

The Factor of Safety. In the matter of safety, it is hard to lay down general rules as to what makes a safe company—and this despite the fact that company safety is an important factor to consider in buying insurance.

The amount of insurance a company has in force has little to do with safety. Insurance in force is a liability; it represents the amount of money the company has contracted to pay at the maturity of all existing policies. At first glance, it might seem that the amount of insurance in force in a given company could be so small as to render the law of large numbers inoperative. However, the small company usually retains a lower amount of insurance. Through reinsurance it gains the necessary spread of risk.

The size of admitted assets taken alone has little to do with safety. The assets must be viewed in terms of their quality and the extent to which they are in excess of realistic reserves.

The real factors are underwriting standards, quality of investments, and the relative amount of surplus.⁵⁰ The law sets the minimum standard for investments. The extra margin of safety is in the skill of the investment men employed by the company. When there is actually doubt about the margins of safety in a given company, the insurance department of the state will provide the most accurate factual information available. The difficulty of judging safety, however, is illustrated by two observations:

(1) Were accurate objective measurement possible, failure of a life insurance company would never occur, for the state department would know when to step in and order a change in practice.

(2) Organizations which rate life insurance companies would not make the mistake they have made in the past, of giving a company one of the highest possible ratings at the beginning of the very year in which the company failed.

Company Prominence. The prominence of a company is often given consideration by the public when choosing a company from which to buy. Prominence indicates that the company is well advertised and well represented, but it should not necessarily be a consideration. It is well for the buyer to remember that there are approximately 1,500 legal reserve life insurance companies in the United States alone, and that the typical layman does well to name more than half a dozen. It certainly would be fallacious to say that all those he cannot name are not sound. It would be much the same as saying that anyone a man cannot call by name is not worth his knowing.

8. SUMMARY.

Broadly, life insurers may be classified as proprietary, mutual, and state. Proprietary insurers are those in which investment-seeking individuals provide the capital, retain voting rights, divide the profits, and share the losses. Mutual insurers are corporations writing insurance on the general public, in which policyholders retain the voting rights, divide the profits, and, in theory, share the losses. Because mutuals cannot assess policyholders for losses, they load the premiums to make sure there will be no losses, returning the unused portion as a dividend, usually at the end of the premium year.

In addition to stock and mutual insurers, life insurance is written by fraternal, assessment societies, and, in three states, by mutual savings banks. Also the state and federal governments have entered the life and health insurance business.

Variations among companies usually arise because the business is competitive, and each company, therefore, differs in some measure from any other company.

⁵⁰ The exact nomenclature for items making up "surplus" varies from company to company. The most common names are "surplus funds," "general contingency reserve," "mortality fluctuation reserve," "unassigned surplus," "capital stock" (if any), and "special surpluses." The ratio of surplus to reserves is one objective measure of safety.

It is possible to take the many variations among companies and with them prove that any one company is better than any other company and that all companies are better than each company. The task of choosing a "best company" is so shot full of "if's," "and's," "but's," and other qualifications that even for the expert the task is impossible. Equally impossible, then, is the task for the layman. No man will get lost quicker than the man who sets out to find the "best" company.

Finding the "best" life insurance company is like trying to solve a puzzle. It looks easy in the beginning. But an hour later you throw the puzzle out the window and, in exasperation, declare, "*I give up!*"

You start on the theory that if you find a company paying high dividends, your search will be ended. Then someone suggests that you had better find out if the dividends are being paid out of actual savings. Next you start to find the lowest net cost company, and someone suggests that you find out if the low net cost is offered at the expense of a constant decrease in the safety margin. Then you start out to find the company with the lowest mortality, and someone suggests that perhaps low mortality is offset by high expense ratios. Finally, you find a company with a rate 25 cents lower than the company of your second choice and are about to buy, when suddenly you discover a clause in the second-choice company's policy which is *worth* 25 cents more. So you start all over again to find the "best" company, and you end with the same baffling conclusion.

The answer is that unless you find a good life insurance agent and believe him, you'll pursue your phantom search for the "best" company until it is too late for protection to do your family any good. The strength of the strongest company, the lowest net cost of the lowest net-cost company, mean nothing to the widow and family of the man who was so intent on buying insurance in the *best* company that he failed to buy it in *any* company at all.

QUESTIONS FOR CLASS DISCUSSION

1. A friend of yours asks you whether he should buy his life insurance in a mutual company or a stock company. What advice can you give him?
2. Your brother-in-law wants to know whether he should buy participating or nonparticipating life insurance. Could you help him make a decision?
3. How does a fraternal life insurance company differ from an assessment insurer? Are they in any way alike? Discuss.
4. Which of the following types of insurers are legal reserve: stock companies, mutual companies, fraternal, assessment companies, National Service Life Insurance, Wisconsin State (Life) Fund, savings bank life insurance, Social Security? Which of the above are so-called old line companies? What is the significance of the two terms?
5. From which of the above types of insurers would you expect (a) better service, (b) lower cost, and (c) greater security?

6. The following is a quotation from a speech before a group of life insurance men: "People think most of the time that life insurance costs money, and you want to dissuade them from that erroneous impression. Life insurance is absolutely free." Why did the speaker make such a statement? Do you agree with the statement? Why or why not?
7. Is it better to assume that good companies are represented only by good agents or that good agents represent only good companies?
8. Under what circumstances is \$10,000 of NSLI worth more than a \$10,000 benefit from an insurance company?
9. A friend of yours tells you that he has been approached by a salesman from the Good Life. Since he knows you are studying life insurance, he asks you what he should know about that company before he buys. What would you tell him?
10. Some people criticize Social Security because it is too much like insurance; others criticize it because it is not enough like insurance. If you had to take sides, which side would you take?

CHAPTER 25

Company Organization and Agency Management

The organization of a life insurance company breaks into two distinct divisions: home office and field. The purpose of this chapter is to discuss the basic patterns of organization in each division.

1. HOME OFFICE ORGANIZATION.

Fundamentally, the organization of a life insurance company home office follows the basic principles of any business organization. It may be *line*, with all authority tracing back to one individual, usually the president; it may be *line and staff*, with executive officers assisted by advisory staff officers or departments; it may be *functionalized*, with staff officers empowered not only to advise but also to act; or it may be *committee*, with major decisions being made by the heads of interested or concerned departments, each contributing his specialized knowledge to any given problem. Commonly, the organization in any given company is a combination of several if not all four of the basic types. This is a result of the fact that a company rarely selects any one type of organizational structure consciously. Patterns grow as a matter of evolution.

Source of Authority. Stockholders in a stock company, or policyholders in a mutual company, are the primary source of authority. They delegate their authority to the board of directors. The board of directors, in turn, will usually retain some of the authority and delegate the rest to the executive officers of the company. It is these officers who exercise the direct, working control of the business.

Where authority goes after leaving the executive officers depends upon the individual company and usually upon the size of that company. The larger the company, the more numerous are the levels of authority.

The Board of Directors. Aside from its appointive functions, members of the board also may serve on committees which pass on certain phases of company administration. This is particularly true in the larger companies where the board of directors has, otherwise, little or no direct contact with the business. The committees of the board of directors, not to be confused

with administrative committees at the executive officer level, are delegated special authority by the board of directors.

The most common board committees are the *executive committee*, which considers questions of general business methods, rates, types of policies, territories; the *finance committee*, which concerns itself with questions of investment policy and practices; and the *auditing committee*, which audits the accounts of the company periodically, usually by the employment of a professional auditing firm. Additional board of directors' committees may be found in various companies, their nature depending upon the special needs of the company or, often, upon the special interests of certain members of the board.

Executive Officers. The *company president* generally is the operating head of the business since usually not all members of the board are full-time employees.¹ The president has general administrative supervision over all departments. Sometimes, especially in smaller companies, he may retain the actual control of the department through which he has risen to the presidency, and sometimes he may perform active duties in several or even all departments. Practically speaking, the president exercises most of the authority delegated by the stockholders to the board of directors between meetings of the board. In truth, as in other kinds of companies, it is not uncommon for the board actually to be under the control of the president. It will be seen in Chapter 26 that one of the criticisms by the Armstrong investigating committee in New York in 1905 was that directors and trustees did not check effectively on management and that board committees "rubber-stamped" approval of management requests or actions. The Armstrong committee recommended steps aimed at the elimination of this situation. Practically, however, it is only natural that in some instances the president is in actual control of the company, since life insurance companies, like other businesses, may be organized and built mainly through the impetus of some one individual who naturally gravitates to the position of control. He commonly exercises that control from the position of the presidency regardless of the fact that technically he is subordinate to the board of directors.

Often, in cases of domination of the company by one man, the primary qualification of a candidate for the board is amenability to the wishes of the president or controlling management bloc. Secondly, the consideration will usually be the prominence of the candidate and hence his publicity or public relations value. Actual control of a company by the president is neither the general rule nor the exception; moreover, such control is not necessarily an unhealthy condition. While it can lead to ill effects, it can also, if the president is a man of outstanding ability, be even more efficient control than that of a less efficient Board. Whether such control exists and whether it is good or bad is an individual matter in every case.

¹ Occasionally, the chairman of the board of directors (who may be the immediate past president of the company) exercises the operating control of the business.

The *vice-presidents* in most life insurance companies exercise active supervision over one or more departments, according to the size of the company. In a small company a vice-president may have to "double in brass" and serve as the head of more than one department. In line of authority, a vice-president acts in the absence of the president. In larger companies vice-presidents are usually co-ordinated by an executive vice-president, the "vice-president in charge of vice-presidents." Now and again, a company will be found in which the executive vice-president actually performs the functions of the president, the position of presidency in that particular company at that particular time being more honorary than active. There have been instances in the past of the appointment of a well-known public figure as president of a company even though he knew little about life insurance operations and did not necessarily exercise active control. In such cases control is in the hands of an executive vice-president, or perhaps is split among several vice-presidents.

Especially in the larger company having a number of vice-presidencies, the title of vice-president is sometimes conferred as an honor upon a department head of long and faithful service who is never expected to function in the capacity indicated by the etymology of the title "vice-president."

The *company secretary* usually has responsibility for correspondence (in the sense of directing authority for official correspondence), the issuance of policies, which are usually signed by the secretary, and the records of the board of directors and committee meetings. These duties are wholly supervisory. Policies are actually issued by a policy issue or similar department with the secretary's signature printed on the form; and the transcript of the business of the meeting of the board or of a committee is usually made by a professional stenographer.

As a result, functioning duties of a company secretary vary widely among companies, ranging anywhere from active charge of a department in no way concerned with his bylaw duties to the function of general manager or even executive vice-president. Moreover, as an outgrowth of this wide variation in the active duties of a company secretary, "assistant secretaries" will be found to be numerous, especially among larger companies, with duties varying as widely as can be imagined within one company.

The charter or bylaws of any given company may add other executive officers. For instance, the treasurer or controller, medical director, and general counsel (attorney) may be executive officers.

Functional Officers. Other officers, unlike the officers so far named (who are executive officers) are common among most companies. They are what might be termed "functional" or "ministerial" officers. While the duties of functional officers may be necessary in the operation of the company, they are not officers of the corporation or organization. They do not have power directly delegated by the charter or bylaws to bind the company, as do executive officers.

Usually, functional officers head various departments. For instance, the company treasurer or controller may be a functional officer rather than an executive officer. The same may be true of the medical director or the legal counsel. Often functional officers eventually are elevated to positions as executive officers by promotion to a vice-presidency. Thus, while the office of medical director may not be recognized by the charter of the company as an executive office, the medical director may be made an executive officer by promotion to the position of "vice-president *and* medical director." The assistant secretaryships previously mentioned are, in most companies, an example of functional officers who are not executive officers.

Functions of Standard Departments. The bases of departmentalization vary from company to company, and they may vary within any one company. Most of the departments of a company are organized along functional lines, although there may be one or two departments organized along product or territorial lines, or lines of executive interest.²

The Agency Department. In every life insurance company having a field agency organization, there is an agency department. It is usually headed by an executive officer, often the "vice-president in charge of agencies." He may, however, leave the actual working operation of the department to a "director of agencies," "superintendent of agencies," or functional officer of similar title. Sometimes there is no executive officer directly in charge of the agency department, the operation of it being in the hands of a functional officer who is responsible to some general executive officer, usually the president.

The primary function of the agency department in most companies is to recruit, train, supervise, and handle most of the affairs in connection with general agents, branch managers, and agents. The agency department usually is supreme in all matters concerning the field organization. The legal department, however, operates as staff adviser to the agency department in such things as the drawing up of contracts for use with general agents and subagents and in similar matters involving purely legal technicalities. The actuarial department advises concerning the scale of commissions.

The agency department may be supplemented by an educational depart-

² Functional departments based upon functions performed, for example, are a medical department, a legal department, an investment department, an agency department, an advertising department, a purchasing department, an accounting department, etc. Product departments are based on type of product with which they deal, for example, a health insurance department, an ordinary department, an industrial department. Territorial departments, determined by the territory over which they exercise jurisdiction, may be an East Coast department, a West Coast department, a South Atlantic department, a Latin American department, or European department. Examples of customer departments, established by the nature of the class of customers with which they deal, are reinsurance (which deals with sales to other insurance companies) and group, often including salary savings and pension trusts (which sells only to employers and in the mass rather than to individual policy buyers). Finally, departments may be organized along the lines of the interest of any given executive or executives in the business, even though those interests may be somewhat diverse.

ment, a sales promotion department, and an advertising department—one or all.

In some companies certain staff departments take over active direction of specific phases of agency operation. This is particularly true in the case of educational departments. As the training of field men is increasingly stressed by companies today, more and more educational or training departments are assuming charge of the training of agents. Their authority then becomes direct instead of simply advisory.

More often than in the case of any other department in the home office organization, the agency department operates virtually autonomously. This usually is a result of the departmental evolution of the company. Although it is by no means a common practice, it is not an unknown practice for a small or new company, formed by interests who are primarily acquainted with investment matters, to make a contract with another organization, usually formed for the purpose, to be the agency organization of the company. This corresponds to a recognized practice in general business. A manufacturer or processor may contract with a sales organization to be its exclusive selling agent. The sales agent then becomes the field organization of the manufacturer or processor, just as one may become the agency department and field organization of a life insurance company. While such an agency may long ago have become an integral part of the home office organization, much of its original, autonomous nature may be preserved in the functioning of the agency department.

Another line of evolution produces a virtually autonomous agency department, the process of the absorption by one company of another mainly because the company absorbed or purchased has a more extensive and better functioning field organization than does the purchaser. In such a case the president of the absorbed company may become vice-president in charge of agencies of the dominating company; but because the field organization was originally his, he may operate virtually autonomously.

The Underwriting Department. The function of the underwriting department is to set the standards of selection and to pass judgment upon applicants for insurance. In some companies the underwriting and the medical departments are one and the same; in other companies the medical department is a subdivision of the underwriting department, or vice versa. They are usually headed by a functional officer known by a title similar to "chief underwriter" or "medical director." In some instances he may be an executive officer. Again, the functional office of chief underwriter may be under the co-ordinating supervision of a vice-president in charge of underwriting, a general vice-president, or the company president. The department is staffed not only with physicians but also with specialists known as "lay underwriters," to distinguish them from physicians. Most underwriting decisions do not depend upon a physician's opinion.

The Actuarial Department. While by derivation the term "actuary" can

designate a registrar or a clerk, it is now almost exclusively applied to a specialized mathematician in an insurance company who calculates insurance rates, dividends, reserves, and commission scales. He also works in the development of new policy forms and settlement options. The term is little known outside the insurance business and means nothing to the typical layman. The functions and duties of an actuary are perhaps more clear if he is called, as in some Canadian and English companies, "chief mathematician."

The functions of the actuarial department in any company are merely those of the aforementioned calculation of degree of risk and their interpretation in terms of rates through the application of level-premium formulas. The actuarial department determines the reserve necessary, advises as to what it considers sound contingency reserves and surpluses, sets the basis for installment settlements of proceeds, determines proper expense loadings, works out dividend formulas and, in short, performs all those functions in the business which are fundamentally matters of mathematics. Since life insurance is founded on mathematical principle, the basic importance of an actuarial department can be easily understood. Because of the specialized and technical skills required for the job, actuaries command one of the best salary scales in a home office. Often only the salaries of one or two higher executives and the earnings of a few of the top general agents and agents of a company will exceed those of the actuary who, if not an executive officer by virtue of his function, is usually one through a vice-presidency. In a great many companies the leading actuaries' principal functions actually are executive.

To the purely mathematical duties of actuarial departments of a small company are often added duties which in larger companies devolve upon a "policyholders' service" department. It is the duty of this latter department to handle matters relating to special optional settlement or trust agreements requested by policyholders. Since the nature of such agreements is fundamentally mathematical, the performance of these duties often lodges in the actuarial department.

The Legal Department. The title of a legal department virtually explains its duties. While the basis of life insurance is mathematical, its operation is primarily legalistic. Since a life insurance policy is a contract and, as such, is subject to all the law pertaining to contracts in general as well as to those phases of the law and judicial opinion which apply particularly to life insurance, a legal department is of prime importance to a life insurance company.

Not only does the department concern itself with the legal problems involved in the development of policy forms, but it often is assigned the duty of drawing up contracts with general agents and subagents, assuring conformance of the company's operations to the domestic insurance code, to the foreign insurance codes of those states in which the company operates, and to any alien insurance codes involved. It is the further duty of the legal

department to defend the company in the case of any informal complaints brought against it through various insurance commissioners and in actual litigation, and to prosecute the company's case wherever it may be the plaintiff. The legal department also renders a service to the investment department of the company. It checks on real estate titles, bond indentures, and corporate charters, and it aids in any foreclosure proceedings.

Investment Department. As in the case of the legal department, the functions of the investment department are almost fully explained by its name. It concerns itself with the creation, maintenance, and liquidation of the investment portfolio of the company.

Other Departments. The above are the major departments common to most life insurance companies. In some companies one or more of these departments may be amalgamated, or one may be a division within another; moreover, in many companies, there are additional, well-defined and well-organized departments—the policyholders' service department mentioned previously, the policy issue department, the controller's department, the secretary's department, *et alia*. Larger companies may departmentalize such functions as advertising and sales promotion (usually subdivisions of the agency department); public relations; publications (company magazines, bulletins, sales literature); purchasing; personnel; and many others.

2. FIELD ORGANIZATION.

The field organization of a life insurance company is primarily a sales organization. Its purpose is to sell new business, to maintain old business in force, and to service policyholders. Of these three purposes, the first is by far the most emphasized.

Types of Field Organization. The field organization of a life insurance company is under the direction of the home office agency department. For the organization of the field forces, one of two systems may be used: the general agency system or the branch office system. While a company rarely organizes its field forces any more under a *pure* general agency or branch office system, before adaptations of the two systems can be understood, it is necessary to know the nature of each.

General Agency System. Under the pure general agency system, a contract is signed with an individual giving him exclusive rights to represent the company and solicit new business in a specific territory. The contract calls for a fixed scale of commission payments and sometimes a collection fee to be paid to the general agent. The general agent is empowered to appoint subagents, or what are known as "special agents" or simply "agents," within that territory and to make contracts with them under which he agrees to pay them a certain portion of the commission he receives from the company. The difference between what the general agent receives from his company and the amount he pays his agents is known as his "override" or "overriding commission."

It should be noted that agents' contracts are made with the general agent and not with the company. In the pure general agency contract, the company, theoretically, has no control over the contracts made by the general agent with his agents, although in actual practice the company usually specifies the form of contract to be used and reserves the right to reject agency appointments.

In the pure general agency contract, the company does not obligate itself to pay any part of the cost of establishing the agency, of operating it, or of developing the territory. On the other hand, it assumes no authority over the methods of operation except within the broad limits of company policy, and no authority or part in the selection, training, supervision, or disciplining of the agency force appointed by the general agent over the personnel of his agency office. The general agent is responsible for collecting premiums, being obligated under his contract to submit only the "net"³ to the company. He is responsible also for the collection of interest on loans as well as the servicing of policyholders and, in fact, of every and all company operations within the territory granted in his contract.⁴

It will be seen, then, that the general agent is an independent operator and that a general agency is an independent business owned and operated by the general agent under his contractual arrangement with the home office. He pays all his own expenses; he finances agents when financing is required; he pays all clerical salaries for the agency and all furniture, fixture, and rental expenses involved. The only control the company has over him is its right to void his contract. Usually such cancellation can be for violation of contract terms or without cause upon due notice from either party.

Branch Office System. The branch office system in the direct counter-type of the general agency system. The branch manager, corresponding in function to the general agent, is not an independent operator and his office is not an independent business. He is a salaried employee of the home office, hired to manage a particular territory. He may receive commissions in addition to his salary; but this does not alter his status as an employee. He appoints and supervises the agency force on behalf of the company. Sometimes he supervises the clerical personnel of the agency; although in larger branch offices it is the practice for the company to employ a cashier as the manager of routine business and collections. The cashier may or may not be subject to the authority of the branch manager.

³ The difference between the premium collected from the policyholder and the commission owed the general agent. This is not the "net premium" described in the chapter on premium computation. This confusion in terms is the reason the authors wish God-speed to the Commission on Insurance Terminology.

⁴ Earlier general agency contracts went even further in their grant of authority. One between the Northwestern Mutual Life Insurance Company and Dr. Henry Martin, dated August 22, 1861, not only authorized the doctor to solicit business, appoint agents, receive premiums, and service policyholders but also to make mortgage loans and *examine his own applicants!*

In the branch office system, the company pays all expenses of operation, trains the agents or supplies the branch manager with the facilities for training them, issues contracts for subagents, and passes upon the qualifications of new agents whom the branch manager may propose. Branch offices are sometimes called "managerial agencies," and the branch office system is sometimes called the "managerial" or "manager system."

Selling Without Agents. Several insurers write insurance without the use of agents. Included in the group are legal reserve insurers such as the Teachers' Insurance and Annuity Association, the Presbyterian Ministers' Fund, savings bank life insurance, and the Wisconsin State (Life) Fund. A number of assessment insurance societies also write life insurance by mail. Many of the last-named have been the subject of severe criticism by various state departments of insurance. The use of the mails, however, cannot be restricted by state law, and a mail-order company may solicit business in a state in which it is not licensed as long as it does not appoint agents in that state or send agents into it.⁵

Comparison of Field Systems. In actual practice, pure general agency systems and pure branch office systems are difficult to find. There is a growing tendency for the company to assume more and more responsibility for the financing and operation of the general agency, thus bringing the general agency system closer to the branch office system for practical purposes, even though the basic relationship between the general agent and his company is unchanged. Several advantages and disadvantages of the two types of field organization in their pure forms are apparent.

Advantages of the Pure General Agency System. The primary advantage of the pure general agency system from the standpoint of the company is its lower initial cost. Since the company assumes no part of the financial burden of operation, theoretically it can open new general agencies without limit as to number. If the agency established does not prove successful, the company has lost no money.

A second advantage of the pure general agency is that business often comes in more quickly after the establishment of the agency. In the first place, the general agent, paying expenses out of his own pocket, may be more aggressive in soliciting business. In the second place, the general agency system, offering a man a chance to have his own business, attracts an enterprising type of person. In the third place, the general agent, being in full authority, can cut through the red tape that sometimes delays the production of business in the new branch office. The branch manager often must refer many matters to the home office for decision before he can go ahead.

A third advantage of the pure general agency system is the flexibility

⁵ A degree of federal control over mail-order insurance has been established by the FTC, and there has been some pressure in Congress for legislation effecting even greater federal control.

with which it can adapt to local conditions. Usually, the general agent is himself from the territory and knows what is required for successful operation in that territory. Being in a position to make his own decisions without consultation with the home office, he can make them on a basis of what he knows local conditions to be. The branch manager can simply report local conditions to the home office, which may or may not give them consideration. Finally, among advantages of the general agency system is the fact that it is far less trouble and work for the home office. The entire job of training, supervision, and motivation can be lifted completely out of the home office and put into the hands of the general agent.

From the standpoint of the individual general agent, the big attraction is the independent nature of his operation. Not only is he the supreme authority in the operation of the agency and within the territory, but he also builds a financial equity in the agency as a business enterprise. He can take his entire field organization to another company should his own sever its contract with him or should he become dissatisfied with his present relationship. He can use his own ideas for selling, promotion, training, supervision, and every and all operations of the agency.

Disadvantages of the Pure General Agency System. One disadvantage lies in the fact that the company, under a pure general agency system, has virtually no control over its field forces. It cannot select its own agents, and it cannot train them. Those men to whom the general agent has delegated certain powers of agency on behalf of the company are employees of the general agent and not of the company. Yet the company is legally bound by their acts.

A further disadvantage of the general agency system is that it can lead to conflicts in sales policy. Whereas the company may recommend conservative sales practices, the general agent may use his own judgment; instances could be cited in which highly promotional (or "high-pressure")⁶ types of selling, not judged to be of the best professional standards, have been practiced by a general agency without the sanction of the company. Without very close control over its general agents, the company is unable to "police" the sales policy of its field organization.

The general agency system may also limit the financing of new agents. Since the financing under this system in its pure form must be out of the pocket of the general agent, it will often have to be more limited than the company could undertake. Often the general agent will neither be willing

⁶ The term "high-pressure selling," as used here, means the inducement of the prospect to buy without either giving adequate consideration to his needs for the product purchased or bringing him to see his need clearly even though completing the sale. By "high-pressure selling" we do not mean the use of persistence, persuasion, and emotion to prod into action the individual who has a clear need, who sees that need, but who delays buying simply because he does not want to sacrifice the luxuries the premium money will buy today.

nor able to give new agents the kind of financial backing that is required to attract the calibre of men which the company might like to have.

Advantages of the Branch Office System Since the pure branch office system is the counterpart of the pure general agency system, its advantages and disadvantages may be discussed in terms of the disadvantages and advantages of the other system. Whatever appears as an advantage in one system shows up as a disadvantage in the other.

Under the branch office system, the company has direct control over the agents because those agents are hired, trained, and supervised by a salaried employee of the company, the branch manager. Since the company usually has greater facilities and resources than are available to any of its agencies, it is able to formulate and administer, or at least assist in the administration of, more carefully worked out systems of selection and training. Since the company works directly with the agents, it has closer contact with its policyholders. Sales policy can be more uniform because the company not only can establish a sales policy but also see that it is carried out. There is more uniformity of operations among all branches because the company can formulate the operational policy of the branch and, having direct salary control over the manager, make sure that the policies laid down are followed. Thus, the same set of rules and regulations will be found in every branch of the company rather than widely differing sets of rules and regulations, as may be the case under the general agency system.

Disadvantages of the Branch Office System. Since under the branch manager system the company underwrites not only the income of the manager but also all expenses of operation, rent, furniture and fixtures, clerical salaries, and operating costs, the branch manager system is much more expensive, at least at the outset. Moreover, the operation of a branch office field organization demands a stronger home office agency department than would be necessary if all matters relating to the operation of the field offices were left to the judgment of a general agent.

Finally, the branch office system is less responsive to local conditions. By nature of organization, a greater proportion of the decisions are made by the agency department in the home office, where the knowledge of local conditions cannot be as complete as that of those who are "on the ground." There is always a chance that what may seem a perfectly logical decision to the home office will not take into account important local conditions. Theoretically, this danger is offset by the fact that the branch manager is on the ground and should be able to advise the home office regarding peculiar local matters. Practically, however, many a branch office manager could tell at least one or two stories of decisions made without or against his advice which had not taken local conditions into full consideration.

Conclusions on Field Organization. Just as every football play, if properly executed, is designed to carry the ball for a touchdown,⁷ so either

⁷ The athletic member of the class will undoubtedly point out that there are certain

the general agency system or the branch office system is designed to yield perfect results in field organization. The fact that relatively few plays in any football game do go for a touchdown is not the fault of the play as planned but of its execution. Similarly, the degree by which either the general agency system or the branch office system fails to achieve perfection is a result of execution rather than inherent nature. Therefore, which may be the better system for any given company and in any given territory depends upon the company and upon the available personnel to man the offices. In recognition of this fact, some companies use general agencies in certain localities and branch offices in others; and further recognition of it lies in the current tendency to combine some of the advantages of both while retaining the outward form of one, usually the general agency system where this combination is attempted.

As has been stated previously, this discussion of the two systems has been of their pure form. Actually, the distinctions between them, once clear, are now blurred. There could undoubtedly be found examples of general agencies which are more closely controlled by the home office than are some branch offices. In general, at the present time, there is a trend toward more and more staff services from the home office for both general agencies and branch offices—and often, even in the case of general agencies, of functional assistance out of the home office—home office trainers being a widespread example.

Internal Organization of a Field Office. The over-all objectives of a field office are to service old policyholders and to secure new policyholders. These functions may be classified under two headings: office functions and sales management functions.

Office Functions. The internal organization of any field office will depend upon what is best suited to its size and available personnel. In general, however, the office functions in any agency, whether a general agency or a branch office, are the collection of premiums, the maintenance of policyholder records, and policyholder service in such matters as the negotiation of loans, execution of change of beneficiary request papers, answering inquiries, and communicating with the home office. In most cases such services are not sought by the policyholder directly, but through an agent. The details of handling them are most often left within the scope of the cashier's department.

The administration of the purely clerical affairs is a function of the cashier's department. In most branch offices and in many large general agencies, the management of all clerical personnel will be within the scope of the duties of the cashier. Often in the branch office system these functions are exclusively the province of the cashier, who may be on virtually the

football plays the purpose of which is to put the ball into a desired position and which cannot be diagrammed as touchdowns. However, we prefer that he keep that little matter to himself, since revelation of it will spoil an otherwise perfectly good analogy.

same level of authority as is the branch manager himself. In the general agency, of course, all employees are employees of the general agent

Sales Management Functions. In addition to the clerical functions performed by a field office, there are the sales management functions, which include hiring, training, and supervising field personnel, and all phases dealing with the promotion of new business.

"RECRUITING" is the term used commonly not only in the life insurance business but also in all types of selling to denote the process of finding and hiring new men. Practically every life insurance company field office is always on the alert for new sales personnel. To some extent, this continual search is a result of the turnover in agents, i.e., of agents leaving the business. Much criticism has been made of this turnover. In the past the lack of valid criteria by which to judge the potentialities of a prospective agent, poor training, poor supervision, and the fact that, under some types of agency contracts, the general agent stood to make an immediate gain if a man left the business before his renewals were vested⁸—these factors have undoubtedly contributed heavily to the turnover. They are becoming less a factor as companies take a firmer stand on the qualifications of men hired by their field offices, as agency heads realize the cost of turnover, as aptitude and vocational interest tests become more widely used, and especially as life insurance education and training become constantly stronger.⁹

SELECTION is, of course, a part of the recruiting function. While rule-of-thumb judgment of the fitness of men for the job of life insurance selling is still practiced, valid and reliable aptitude and interest tests have been worked out and are widely used for preliminary screening of applicants for jobs as life insurance salesmen. The tests have been more useful in predicting failure than in predicting success; i.e., one can be more sure of the failure of a man scoring low than he can be of the success of a man scoring high. These tests, therefore, do not guarantee success but do eliminate from further considera-

⁸ Under the terms of many contracts between general agents and subagents, the subagents' renewal commissions were not vested until the agent had filled certain conditions of (1) length of service and, especially, (2) amount of production during a given period. (Renewal commissions are said to be "vested" when the agent is guaranteed payment of them regardless of whether he leaves the general agent.) Under what was once the common type of general agent's contract, nonvested renewals reverted to the general agent when a man left the business (That is, the general agent, having a contract with the company calling for the payment to him of 7½ per cent renewals, say, and having himself granted an agent 5 per cent of the 7½ per cent, would, when an agent quit the business, again receive the entire 7½ per cent on all nonvested renewals which the agent left behind.) Consequently, it was to the general agent's profit to recruit agents who would write their friends and relatives and then, unable to write others, would leave the business.

⁹ It might be pointed out that turnover in personnel is not peculiar to life insurance field offices or to sales work in general. The fact that high rates of turnover are to be found in other businesses also, is, of course, no justification for such turnover among life insurance agents. However, there has been a tendency, perhaps, to emphasize turnover among agents in such a way as to make it appear to be a problem peculiar to the insurance business.

tion men who are not likely to succeed. Tests will not measure a man's willingness to apply himself or his ability to build a market.

TRAINING is an important sales management function. To be successful, an agent must not only have a reasonably good understanding of insurance but also the technique of presenting his story so that the prospect will buy.¹⁰

Training in the life insurance business consists of (1) acquiring technical knowledge and (2) developing skill in selling. Knowledge alone will not make a life insurance salesman. The home office actuary, for an example, has more pure knowledge about life insurance than the most successful agent; but few are the home office actuaries who could keep up the sales pace of even a mediocre agent. On the other hand, sales skill without knowledge rarely leads to permanent success in life insurance selling.

Ideally, the acquisition of knowledge should come from formal education, and the application of that knowledge ("skill") should be taught in the business. Unfortunately, despite the vast increase in academic courses in life insurance since World War II, there are still too few people with formal education in life insurance to satisfy the need for agents. Therefore, training plans and courses offered by agencies, companies, and at the institutional level have to start off with imparting knowledge.¹¹

In contrast to an earlier day in the business when training consisted of giving the new man a rate book and a pat on the back, there is today a plethora of training "plans" and "programs." These programs are of several kinds: agency or company, commercial, campus, and institutional.¹²

SUPERVISING and motivating agents also are functions of a field office.

¹⁰ The difficulties involved in selling life insurance are much the same as those involved in "selling" religion. Both call for giving up present pleasures for future rewards. The job of the life insurance agent, like the job of the minister, priest, or rabbi, is to convince men that the satisfaction that comes from having done what they know is right will be greater than the satisfaction from the present pleasures that must be foregone. In truth, selling life insurance calls for a touch of evangelism on the part of the agent. The authors have never known a career life insurance agent who wasn't evangelistic about his work, determined to convince people for their own salvation. No sacrilege is intended by this comparison. It was first brought to the attention of the authors by a minister of the gospel.

¹¹ Unfortunately, since it is easier to impart knowledge than to teach skill, too many training courses concentrate on the former to the neglect of the latter. Whereas part of the turnover among agents can be attributed to inadequate training, some turnover can be attributed to too much concentration on "education" to the neglect of "training." Life insurance training could take a lesson from medical training. Even after a medical education has imparted knowledge up to the highest academic degree, the doctorate, it does not allow the possessor of that knowledge to practice medicine until he has had at least a year or two of internship—which is training in skill as contrasted to knowledge. Unfortunately, there is in life insurance too great a body of thinking which considers knowledge alone enough for agent training.

¹² Agency or company training plans run up the scale from nothing more than a booklet of questions and answers designed to help the new man qualify for a state license, to a well-conceived series of training courses extending over a period of several years. The principal institutional programs are those of the Life Underwriters' Training Council (L.U.T.C.) and the American College of Life Underwriters. The American College of Life Underwriters offers a study course and a series of examinations leading to the

Supervisory efforts are aimed at directing and controlling the business activities of the agent. They include working with the men in the field, perhaps actually accompanying them on their calls to observe their methods and technique and to offer suggestions for improving them; requiring reports from the agents regarding their work; analysis of reports with suggestions and criticisms; and the handling of special problems which arise and which may be brought to the attention of the agent's supervisor or unit manager, or directly to his general agent or manager.

MOTIVATING the agent consists of building and maintaining his morale, creating job satisfaction, and developing in him a feeling of importance by constantly reminding him of the prestige that goes with the job of high-level professional life insurance selling. The general agent often must stimulate interest through agency meetings, study groups, sales contests, production clubs (in which membership is based on a number of qualifications, chief among which is usually a stated level of new business) and sales quotas.

SALES PROMOTION functions also are a part of the duties of a field office. The extent and intensiveness of operation in this area depend much upon the type of agency system. In the pure general agency system, virtually all the sales promotion functions connected with life insurance devolve upon the agency. On the other hand, sales promotion services or functions performed within the field office will be limited in the pure branch office organization to those functions which can be performed only locally. For example, in the pure general agency not only the decision regarding how much local advertising is to be done but also the creation and placement of that advertising will be the responsibility of the field office. In the pure branch office organization, however, perhaps the only function the field office will perform in connection with local advertising is the actual placement of advertisements—the number, nature, and media will have been prescribed by the home office. In truth, the only purpose in leaving the placement of the advertising to the branch office is to enable the branch manager to make a personal contact which will be of value in the public relations of the office in the local territory.

The sales promotion services in a field office may consist of the preparation of sales literature and visual aids, the drawing up of personal or business life insurance proposals for the agents or assistance in drawing them up, the building of prospecting lists, the aforementioned creation or placement of advertising, and the operation of a direct mail system of advertising. Which of these will be performed in any given field office depends, as stated, on the nature of the organization of the field forces and the policy of the company.

award of the professional designation, "Chartered Life Underwriter," usually abbreviated as "C.L.U."

Compensating the Agent. Compensating agents is another major sales management function. As with salesmen in general, the basic method of compensating life insurance salesmen is the commission contract. Compensation plans designed for ordinary agents differ from those designed for industrial agents.¹³ The distinction is sufficient to justify discussing the two separately.

Ordinary Agent Compensation. Compensation contracts of ordinary agents usually call for high commissions on the first year's premium with a much smaller commission on future premiums. For instance, what is commonly called the "New York scale" provides first-year commissions of as high as 55 per cent on policies such as continuous-premium whole life and twenty-pay life (the "top-commission" contracts varying with companies) down to as low as 15 per cent on short term and 3 per cent on single-premium forms. Renewal commissions are 5 per cent but are not graded—i.e., they are the same for all policy forms and are payable for nine years.¹⁴ Thus under the "New York contract" the total commission payable during the life of top-commission policies is 100 per cent of one year's premium (55 per cent the first year, plus 9×5 per cent, or 45 per cent).¹⁵

Renewal commissions usually become "vested" (i.e., his renewals will continue to be paid to him even if he leaves the company) if the agent achieves certain levels of production within time periods stated in the compensation contract or completes a requisite period of service such as five, ten, fifteen, or perhaps twenty years.

In recent years, in recognition of the fact that agents are often called upon to give service to policyholders long after the renewal commissions have expired, many companies have augmented the system of first-year and renewal commissions with "service fees" to be paid as continuing compensation after renewals stop. These fees are paid on the basis of the life insurance the agent has in force and are paid as long as the agent is with the company.

Many companies also pay additional commissions or bonuses per \$1,000 of new business paid for,¹⁶ basing the bonus on a satisfactory average-size

¹³ Today the industrial agent is more commonly called a "combination" agent in view of the fact that he nearly always sells ordinary as well as weekly-premium insurance.

¹⁴ There are of course variations in these plans with some few companies paying slightly lower first-year commissions and slightly higher second- (and sometimes third-) year renewals.

¹⁵ A company not licensed in New York might pay more, especially if it is a small company which feels that its competitive situation is such that it must pay more to attract agents. Contracts of these smaller companies often range as high as 90 per cent of first-year premium with some such renewal arrangement as nine at $7\frac{1}{2}$ per cent and five at 5 per cent.

¹⁶ New business may be referred to by the status of the application at any given time. *Written business* consists of applications which have been signed by the applicant but on which no premium has yet been paid. *Examined business* has not only been "written" but also had the medical examination. *Paid business* has settlement for the first premium. *Issued business* consists of policies actually made out by the company but not yet de-

policy or rate of persistency, or a combination of both. There may also be additional compensation, usually in the form of a bonus, for cash with the application or for policies written on an annual rather than a quarterly premium plan. Some companies pay a bonus for larger policies by the reverse process of reducing the commission on smaller policies.

The presence and nature of additional compensation in the form of various bonuses differ widely among compensation contracts and depend on the operating philosophy of the company involved; however, it is usual for one or more of these extra compensation features to be found in any given agency contract.

In addition to straight compensation are various fringe benefits in the form of retirement pensions and group life and disability insurance. In so far as these benefits are available, they represent, in effect, additional compensation.

Companies frequently use other than the commission plan of compensation, especially for new agents. These contracts provide salary in lieu of or in addition to commission. The salary is weighted by and must be validated by production. It is, therefore, tantamount to commuting the commissions of a basic commission contract.

Under the commission contract the ordinary agent earns nothing until he starts making sales. As a result, building up a satisfactory volume of production, and hence income, comes slowly for the typical new agent; therefore, it has become common for companies or general agents to finance a new agent's first months or years in the business until his sales rise and especially until he begins to enjoy the benefit of renewals.

Financing plans are of infinite variations. Several examples are as follows:

(1) **DRAWING ACCOUNT.** The agent is advanced money either on a stipulated weekly or monthly basis or as he needs it. The money is to be paid back—usually whether the agent terminates his contract or not.

(2) **STIPULATED WEEKLY OR MONTHLY PAYMENTS IN LIEU OF COMMISSIONS.** Under this plan, the agent's earned commissions are credited to his account to offset the stipulated payments. Usually the arrangement is to continue for a period of months or even several years, with the agent having the right to stop the payments and take his commissions whenever the latter exceed the former. In case of termination of employment, he usually is not liable for any deficit of payments over commissions actually earned, the

livered to the applicant. *Delivered business* consists of issued policies delivered to the policyholder but not yet paid for. *Placed business* has not only been delivered to the policyholder but also paid for by him. Business is "paid for" if there is settlement for the first premium at any of the above stages. It is not "placed," however, until both paid for and delivered, or delivered and paid for, whichever is the sequence in the particular case. The only business on which the agent actually collects the commission is "placed" business.

trend being toward the "forgiveness" plan (where the agent's debit balance is forgiven).

(3) **STIPULATED PAYMENTS PLUS PARTIAL COMMISSIONS.** The agent is guaranteed a weekly or monthly income. In addition, he is guaranteed part of his commissions. In some plans he has this guarantee regardless of the amount of the commissions and in others only if the commissions exceed a certain amount. These plans provide level income during the starting period plus incentive for increased production. Again, in case of termination of employment, the agent may be liable for any deficit or the deficit may be cancelled. As stated, the trend is toward "forgiving" the deficit.

It should be emphasized that whatever the compensation arrangement established for the new agent, he must show signs of impending success or he will not last. In other words, one has to sell life insurance in order to obtain a living selling life insurance.

In addition to company financing plans, it is possible for agents to help finance themselves. One method is to borrow against renewals; i.e., as soon as an agent has placed a case, he can borrow some of the money which he expects to be paid in the future from that sale. The actual value of the renewals, of course, will not be 100 per cent of their maximum possible value, since a certain percentage of policies will not continue in force until all renewals have been paid. However, banks, loan companies, general agents, and sometimes insurance companies will lend or advance money on the estimated present value of expected future renewals.

Whatever glowing pictures may be painted (and recognizing that exceptions are found), getting established in life insurance selling calls for expenditure of capital by the agent.¹⁷ Either he uses up some of his savings or he has to borrow the necessary capital. The job of life insurance selling is equivalent to going into business for oneself. The established agent is a self-employed businessman.¹⁸ While he may, in a sense, "work for" a given company, he is much freer to change companies than is the typical salaried man. If employment conditions with his company do not satisfy him, he can form a new connection almost overnight, and as far as new business goes, retain virtually all his clients. Moreover, if he has been with his company long enough for renewals to be vested, he also retains income from past business produced for that company.

Combination Agent Compensation. The theory of compensation for the agent who collects and services a debit is different from that for the ordinary agent. The debit agent performs a salaried-type function in his collection activities; hence, he is paid a basic salary expressed as a percentage of collections on his assigned debit. One large industrial writer pays 12 per cent

¹⁷ The young college man often is an exception. If he has no fixed obligations and can live on a close budget for a year or two, he may be able to earn his way while getting established.

¹⁸ Except for Social Security purposes.

of weekly premiums and 6 per cent of monthly debit premiums. This basic salary compensates for the time the agent spends in making collections and the necessary bookkeeping. The fundamental difference between his compensation and that of the ordinary agent is that the man who collects a debit starts out with a "salary" emanating from business previously sold, whereas the new ordinary agent receives compensation only if and when he produces new business.¹⁹

In addition to his basic salary, the debit agent receives a commission on all new industrial business sold. On new debit business, the agent's compensation consists of a graded commission scale with allowances for persistency. In one large industrial writer, the first-year commission rate is 37 per cent, except that for endowments of thirty or fewer years the rate is 28 per cent. Also, when he writes ordinary insurance, he receives the customary ordinary commission payable for this business.

A third source of income to the combination agent is a conservation commission. For example, in one large industrial writer, this ranges from \$3 to \$7 a week, the exact amount depending upon the agent's lapse ratio in comparison with that of the company as a whole.

Some companies pay in addition an annual service bonus, the amount of which varies with the years of service. For example, one company pays \$50 for service of from ten to fourteen years on up to \$200 for service of twenty-five or more years.²⁰

Health Insurance Compensation. The basic method of compensating agents for the sale of health insurance is also the commission contract; however, two different types of commission arrangements are in use.

Whereas the predominant practice in life insurance is to "bunch" the bulk of the total commission payable into the first year, in the casualty insurance field the predominant arrangement is equal first-year and renewal commissions, with renewal commissions being payable as long as the policy is on a premium-paying basis. Inheriting, as it does, from both the casualty and the life fields, the health insurance business uses both types of commission plans, varying from company to company.

The trend among life insurance companies is toward the "unlevel" commission plan to which their men are accustomed, although a different distribution of the renewal commissions is made. For instance, one of the largest life companies uses a 40 per cent first-year commission, 15 per cent second, 10 per cent third, and 5 per cent for the life of the contract. Another life company pays 40 per cent the first year, 10 per cent the second through the tenth years, and 5 per cent thereafter for the life of the contract. On

¹⁹ Except those, of course, who are on one of the financing plans already discussed.

²⁰ While the top 10 per cent or so of ordinary agents will earn more than the average of the top 10 per cent of combination agents, it is not unlikely that the earnings of the average combination agent would exceed those of the average ordinary agent.

hospitalization contracts, both pay a 25 per cent first-year commission, 8 per cent the second through the tenth years, and 3 per cent thereafter.

In contrast is the level commission plan of another large life insurer. It offers 25 per cent flat for the first year and on all subsequent renewals. Usually this plan does not vary the commission scales as extensively as is done in the life field.

The graded commission plan tends to emphasize new business, whereas the level plan emphasizes business that remains in force. Under the level plan, the agent who writes a policy which lapses the first year loses more than does the agent under the graded plan. However, as between the scales illustrated above, if the policy remains in force for as few as three years he is better off. Although the level commission plan seems to emphasize persistent business, it does postpone compensation and this might make it harder for the new man in his first year or two. On the other hand, the level plan permits the building of a larger renewal income, thus giving an agent more vested interest in his business.

Which is the better plan of compensation—level or graded—is a subject much discussed in the business.

3. INTERCOMPANY AND FIELD ASSOCIATIONS.

In the life and health insurance business there are a number of intercompany co-operative organizations and agents' associations, some of which have been mentioned briefly elsewhere in the book but which might be summarized here.

The *Life Insurance Association of America*, usually abbreviated "L.I. A.A.," is an intercompany association devoted to an exchange of information of aid and value at company level, especially in the areas of investments, company management, and company taxation. With headquarters in New York and an office in Washington, it is active in watching legislative trends, suggesting legislation in the field of income taxation affecting life insurance, and offering expert testimony before congressional committees when called upon to do so. Originally considered the "big company" association, it now contains members representative of companies of all sizes.

The *American Life Convention*, usually abbreviated "A.L.C.," with headquarters in Chicago, covers the same fields of activity as L.I.A.A. Originally considered the "small companies'" association, like L.I.A.A., it has broadened its membership until it is representative of all classes.

The *Institute of Life Insurance*, usually called "the Institute," has to date escaped the alphabetical designation that is the lot of most other associations. The Institute, with headquarters in New York, is primarily a public relations organization supported co-operatively by member companies. It prepares news releases on life insurance information of public interest, conducts a constant institutional advertising program in newspapers and farm journals

throughout the country, prepares articles and booklets for distribution to the public and women's groups and through schools, and seeks to answer adverse criticism of life insurance in the medium in which the criticism was published. It also serves as a central source of information and statistics. The Institute, by sponsoring summer workshops for teachers, contributes toward proficiency in family finance and consumer education. The workshops are conducted by universities.

The *Health Insurance Institute* serves the health insurance industry in the same way generally as the Institute of Life Insurance serves the life insurance industry.

The *Health Insurance Association of America*, usually called "H.I.A.A.," is an intercompany of insurers: life, casualty, and monoline health insurance. In addition to performing much the same functions for the health insurer as the L.I.A.A. and A.L.C. do for life companies, it carries on research in occupational ratings and has developed a classification system.

The *Life Insurers' Conference*, often thought of as the "small companies' " association, includes a preponderance of combination (industrial and ordinary) companies, particularly from the Midwest, South, and Southwest. Its purposes are exchange of information and experience in all areas of company operations and management. Headquarters are in Richmond, Virginia.

The *National Fraternal Congress of America* is an intercompany association of fraternal companies for exchange of information and experience and study of investment and actuarial problems peculiar to fraternal operation. Headquarters are in Chicago.

The *National Insurance Association* is an intercompany association of companies specializing in Negro risks, with Chicago headquarters.

The *Life Office Management Association*, abbreviated "L O M.A.," has executive offices in New York City. Its primary objective is to assist in improving life office management through an exchange of experience and research among member companies and the development and administration of an educational program for office employees. Organized in 1924 by a group of officers of eighty-three life insurance companies, its membership now stands at approximately 100. L.O.M.A. organized the Life Office Management Association Institute in 1932 to administer an educational program and a series of examinations. Close to 30,000 home office employees have pursued the courses offered.

The *National Association of Life Insurance Companies* is an intercompany organization of small companies.

The *Life Insurance Agency Management Association*, usually abbreviated "L.I.A.M.A.," is devoted to research in and preparation of aids for life insurance sales management. It is supported co-operatively by companies and has headquarters in Hartford.

The *National Association of Life Underwriters*, usually abbreviated

"N.A.L.U.," is an agents' association, active (voting) membership being confined to agents, general agents, and managers. N.A.L.U. is active in all areas affecting the interest and welfare of agents, including state and federal law and legislation. Headquarters are in Washington, D.C. N.A.L.U. operates through state associations which, in turn, are made up of local associations in cities and towns having enough life insurance agents to support a local organization.

The *General Agents' and Managers' Conference*, usually abbreviated to "G.A.M.C.," is an organization within N.A.L.U. devoted to the interests of general agents and managers who are members of N.A.L.U.

The *International Association of Health Underwriters*, sometimes abbreviated "I.A.H.U.," is the agents' association for men who sell health insurance. Membership among life insurance men whose companies sell health insurance is overlapping with N.A.L.U. However, I.A.H.U. includes casualty and monoline agents who do not normally belong to N.A.L.U.

In addition to these broad company and agents' associations are a number of special-purpose associations with members from all companies—or at least with membership open to representatives from all companies. The following is a list of the better known of them. The name of each is reasonably descriptive of its nature:

- Association of Life Insurance Counsel
- Association of Life Insurance Medical Directors
- Home Office Life Underwriters' Association
- Institute of Home Office Underwriters
- Insurance Accounting and Statistical Society
- International Claim Association
- Life Insurance Advertisers Association (made up of home office advertising men)
- Society of Actuaries

Membership in intercompany associations is not mutually exclusive. Thus a company might belong to L.I.A.A., A.L.C., H.I.A., the Institute, and L.I.A.M.A. There is, however, no such thing as company "membership" in N.A.L.U. or in I.A.H.U., although home office personnel may belong to the former as associate members and to the latter as active members.

4. SUMMARY.

The organizational problems of a life insurance company are not peculiar to that particular type of business, but in the main duplicate those of all business. In other words, sound general principles of business organization apply to the organization of a life insurance company home office as well as to any other type of business operation. Departments may vary, but the bases of organization and the bases of departmentalization are the same in principle.

Since each business is a personality in itself—the reflection of the personalities which make it up or dominate it—no general rules can be laid down regarding the best type of organization for any given home office. Any two home offices, virtually identical to the casual observer, will prove upon examination and analysis to contain differences which make one or another type of organization more suitable. Moreover, no rules can be laid down as to the type of organization which may be most efficient throughout the history of the company. Companies change in size, and as they change, their organizational needs alter. Available personnel and executive interests always must be taken into consideration. The major consideration is flexibility.

In any home office, whatever its organization, authority will always move downward. It begins with the stockholders or policyholders, depending upon the type of company. These are the last court of appeal and the beginning of all authority. By their votes, they can exercise all control over the entire organization. From these stockholders or policyholders, authority moves downward to the board of directors, which may retain part of it in committees of its own and delegate the residual authority to executive officers who have the power to bind the company.

Authority leaving executive officers diffuses through the various departments in a pattern which varies from company to company. Perhaps it goes to appointed executives—who are called “functional” executives to distinguish them from those who exercise authority over operations rather than practical direction of them. From appointed officers it may go to divisional heads or unit supervisors and eventually finds its way down to the lowest level of authority: the individual worker who has responsibility only for his job and not for the work of any others. In a smaller company, lines of authority may flow directly from the executive officers to the individual workers; and in larger companies, they may go through even more steps than those detailed above.

The principal function of departments in a home office are agency, underwriting, actuarial, legal, contract, and investment. Insurance companies also may be departmentalized on the bases of products, territory, or class of customers.

Most businesses have production departments and sales departments. The function of the sales department is to sell the product produced by the plant. In life insurance, the sales department is also the production department because the act of selling life insurance is the act of producing life insurance. The sale of a \$10,000 life insurance policy automatically produces an additional \$10,000 of insurance in force. The agent who sells \$1,000,000 worth of life insurance is called a million-dollar “producer.” It is the primary function of the field organization of a life insurance company to “produce” business.

In general, there are two basic systems of field organization: (1) the

general agency system and (2) the branch office or managerial system. Under the former, field offices are under the control of men to whom has been granted the power of agency not only for the conduct of business between the company and the policyholder, but also between the company and those who represent it in direct contact with the public, the subagents. The general agent is an independent operator who has a contractual agreement with the company under which he operates as a fully independent contractor, subject to the control of the company only within terms of the contract. Under the branch office system, each field office is under the direction of a salaried employee of the home office, resident in the territory over which his field office has authority. The company has direct control over him as over all employees, and hence more direct control over the agents under him than it does over the agents under the general agent.

Neither the general agency system nor the branch office system can be called the "better" system for every given company in every given territory. Each has its merits, and each has its drawbacks. For one company in one territory, one may be the better, while in another territory or for another company the other may be the better. In actual practice the distinction between the two is often hard to perceive except for the nomenclature. There is a tendency among all companies, at the present time, to reserve for themselves more and more control over their field offices, even though they may technically retain the general agency system of field organization. On the other hand, companies which use the branch manager system must frequently add to the manager's contract phrases or clauses which more accurately belong in a general agent's contract, particularly incentive arrangements in the way of bonuses and commissions above salary.

The main functions of a field office are the selection, training, supervision, and motivation of agents, and sales promotion. Although life insurance might function and survive without an extensive field organization, it could not have become the factor in the American economy and American business that it is today. This seems thoroughly proved by the experience of those American carriers which do not have extensive field organizations, as well as by the experience in Great Britain, for instance, where well-developed field organizations are not so common as in America.

QUESTIONS FOR CLASS DISCUSSION

1. How does the job of the president of a life insurance company differ from the job of the president of the local bank?
2. Why do large insurance companies often have so many vice-presidents?
3. What is the most important department in an insurance company?
4. In which department of a life insurance company would you most like to work? Why?
5. If you were going into life insurance sales management, which would you

- prefer to have, a general agency or a branch office? Why? Suppose you were president of the company: Which would you prefer for your company? Why?
6. If you were going to sell life insurance, would you prefer to work for a general agent or for a manager? Why? If you were buying life insurance, would you prefer to buy from a general agency or a branch office? Why?
 7. Is it the job of the colleges and universities to teach men how to sell life insurance? Discuss.
 8. Do you think life insurance agents are overpaid? Discuss.
 9. Why are there so many different kinds of organized associations in the life insurance business?
 10. An important attribute of a job with a life insurance company home office is stability. Why? Is this true in the field (selling)? Why?

CHAPTER 26

Development of the Business

The origins of life insurance are obscured in the mists of antiquity. Nevertheless, since the principle of insurance is an evolution rather than an invention, life, and health insurance can be traced back to any number of forebears. The Chinese had forms of sickness, life, fire, crop, and war insurance from time immemorial. Sections 23 and 28 of the Code of Hammurabi show that ancient Babylon had various forms of government theft and crop insurance as well as an adoption-annuity plan. A Babylonian could adopt a son, rear him, and, for old age security, depend upon his adopted son's legal obligation to provide the necessary funds.

First Contribution Principle. The first evidences of personal insurance on the contribution principle are found in the *Eianoi* or *Thiasoi* of ancient Greece. These benevolent societies, supported by contributions from members, developed into common devices for paying burial expenses of members and the immediate cash needs of their survivors.

Rome early evolved the *Collegia* of the soldiery and the *Collegia Tenuiorum* of the civilians. The funds of the *Collegia* of the soldiery were used to meet unexpected expenses for the soldier, such as those of a costly transfer to a distant post, new equipment necessitated by a promotion, disability and old age pensions, burial, and living expenses of his widow and children. The funds of the *Collegia Tenuiorum* were used to pay for the burial of the non-military citizen and to provide for the most pressing post-burial necessities of his family.

The Guilds of medieval England were in a direct line of descent from the *Eianoi*, *Thiasoi*, and *Collegia*. In their beginnings, the Guilds seem to have had as their main purpose the relief of brethren and their families in time of distress. When the Guilds collapsed under the rising tide of nationalism, their places were taken by the Friendly Societies. Without these societies the artisan class of Great Britain in the first quarter of the nineteenth century would have found it difficult to provide for even the simple necessity of burial. When the scientific laws of mortality were introduced into the life insurance business, the Friendly Societies became the framework on which the new life insurance companies were developed.

1. FIRST RECORDS IN ENGLAND.

While continental theorists and mathematicians contributed much to the development of the science of life insurance, the practical application of

these principles to insurance developed there so slowly that it is better to look to England for background on the development of the life insurance business in America.

Marine insurance had long been established in England when, on June 18, 1536, Richard Martin turned to companions in the Old Drury Ale House, a gathering place for marine underwriters, and suggested that the practice of marine underwriting be extended to the underwriting of the risk of a human life, in this case a fellow drinking companion named William Gybbons (described as a "hale-fellow-well-met sort of individual, rubicund of jowl, healthy of person, and apparently destined to live to the full biblical 'three score and ten'"). Martin, with confidence in his judgment elevated by either a series of lucky underwritings or the ale, proposed to insure the life of William Gybbons for twelve months in an amount of \$2,000 for a premium of about \$80. Fifteen underwriters joined in the proposal. Mr. Gybbons accepted and, as fate would have it, died on May 29, 1537.

Now Richard Martin and his associates, and William Gybbons, for that matter, might forever have escaped the notice of history had not the underwriters been so upset by their bad selection that they decided to contest the claim on the grounds that the policy had been written in terms of a year of twelve lunar months of twenty-eight days each. Therefore, they contended, the policy had expired on May 20. The defense fell when the court laid down the principle of holding against the insurer who draws up an ambiguous contract and ordered the claim paid.

After the litigation over the Gybbons claim, the idea of underwriting lives seemed to become more popular, for there followed 160 years of ever-increasing activity in this field. Gradually, life underwriting became a specialty rather than merely a side line of the marine underwriters. Eventually, life underwriters moved from coffee and pot houses to Exchange Alley where, despite Puritan antagonism and rumors of the sudden, sad, and suspicious demise of many an insured, life underwriting thrived and prospered.

First Life Offices. The first registered life office in England was the Hand-in-Hand Society, established in 1696 by 100 incorporators.

In 1698 the Mercers' Company inaugurated a scheme for granting life annuities to the nominees of member-insurers. The venture, undertaken at the instigation of a Lancashire divine, Dr. William Assheton, author of such delightful Calvinism as *The Certainty and Eternity of Hell Torments*, finally had to be bailed out by the government. The mortality table on which the Mercers' Company proceeded seems to have had little of the certainty the worthy doctor saw in hell's torments.

The Society of Assurance for Widows & Orphans, founded in 1699, was the earliest life insurance association projected in England. It proposed to have members contribute \$1.20 a week for life insurance of \$2,400. The Society, the first of the mutual life offices, introduced selection of risks with regard to health and age; contract exclusion of such hazards as military,

naval, and sea service; a grace period (seven days) for payment of premiums; and waiver of liability in case of legal execution. The ultimate fate of the Society is unknown, although there is evidence that it had obtained only 600 of its proposed 2,000 membership by 1704, and only 1,104 by 1707. Thereafter it dropped below the horizon of recorded life insurance history.

Several other "companies" were projected in the early 1700's but faded quickly from the record. However, in 1706 the Amicable Society for a Perpetual Assurance Office received a charter from Queen Anne. Notably, as its name implies, it offered insurance for the whole of life instead of for a specific term as was common up to that time. However, it was not until 100 years later that the Society attempted to write whole life policies with a fixed face value. During the first century, the death benefit payable was the amount in the fund at the end of a year divided among the beneficiaries of members deceased during the year. The amount payable therefore fluctuated with variations in mortality experience and interest earnings.

The Amicable was the beginning of the end of the dominance of the individual underwriter or underwriting syndicate in the life field.¹ The Amicable was merged with the Norwich Union Life Office in 1866.²

"Old Equitable." The Society for the Equitable Assurance of Lives and Survivorships, familiarly known as "Old Equitable," was established in 1756 to offer whole life, level-premium insurance for a fixed face amount, the mathematical formula for which had eluded actuaries up to that time. When "Old Equitable" issued its first policies in 1762, life insurance as it is known today was born. The company offered a grace period of thirty days, a ninety-day reinstatement provision, premiums graded according to age, and a refund of premium overcharges—which set the pattern for the "dividend" system used today under "participating" policies. The "Old Equitable" continues to flourish to this day.

Coming of Surrender Values. The Scottish Widows' Fund and Equitable Assurance of Edinburgh added surrender values in 1851, and paid dividends in the form of additional, paid-up insurance, one of the dividend options in modern, participating policies. By the latter half of the century, the fund had established branch offices throughout the British Isles and is, today, a representative British company.

In 1801 there were eight going companies in England, and policy transactions amounted to some £17,500,000 with premium income of £650,-

¹ Early insurance was written almost entirely by individuals, alone or in syndicates, who placed their personal resources behind the policy. For years they fought all efforts made by groups to obtain charters to operate as corporate insurers. The stories of these battles make interesting reading. A good, brief account of them will be found in William D. Winter's *Marine Insurance*, New York, McGraw-Hill Book Co., 1952, pp. 14-19.

² Two other of the early life offices call for mention: London Assurance and Royal Exchange, chartered as stock companies to write marine risks in 1720 and to write fire and life in 1721. They did little in the last-named field.

000. By 1850 the amount in force had jumped to £130,000,000 with annual premiums amounting to £5,000,000. Although insurance in Britain has never attained the proportions it has in the United States, British life insurance has continued a steady growth, until today there are well over £10,000,000,000 in force.³

2. EARLY LIFE INSURANCE IN AMERICA.

Colonial America seems to have given little thought to life insurance, even though Benjamin Franklin is quoted as considering it more important than fire and marine insurance.⁴ Only a few scattered life insurance policies were written on colonists and those were by individual underwriters.

A record exists of the opening of a public insurance office in Philadelphia in 1721. This office served as headquarters for marine underwriters who also occasionally wrote life insurance policies. Offices such as that in Philadelphia became rather common in Providence, New York, and all the principal cities of the Atlantic seaboard. The usual life insurance policy was written for a six- or twelve-month term, or for the duration of a sea voyage. Premiums were 5 per cent of the amount of insurance. No medical selection was utilized. Life insurance was purchased only for short-term, extrahazardous adventures. The average colonist had no way of protecting his family against the less dramatic, everyday risks of death. In fact, to do so through insurance was looked upon with disfavor. As late as 1809 a Massachusetts court argued the legality and morality of life insurance.

First Companies. The first corporation in North America to insure lives

³ Concentration on the historical beginnings of life insurance in England does not imply no activity on the European continent. There, development was slower, despite the fact that among the names of contributors to the mathematical development of the life insurance principle are many of Swiss, Dutch, and Italian derivation. As early as 1630 the idea of developing joint stock companies to write insurance was presented in Holland. The Dutch, because of the prevailing high taxes and low investment yields, investigated life insurance and annuities. The idea soon died. A true life insurance company was founded in France in 1787 (*Compagnie Royale d'Assurances*). The trail-blazing company in Italy was founded in 1826 and was, coincidentally, the first successful operator in Austria, since no domestic commercial company was formed there until 1830 (*General Assurance Company of Trieste*), and that was a company writing life insurance as a side line. The first German life company came in 1829 (*Die Lebensversicherungsbank für Deutschland in Gotha*), while in 1835 Pope Gregory XVI founded the *Societa Pontificia d'Assicurazioni Nello Stato Pontificio*, a short-lived venture, significant as the first corporate attempt in Europe to set up a general insurance company to write both life and property insurance.

⁴ Benjamin Franklin is reputed to have said, "*It is a strange anomaly that men should be careful to insure their houses, their ships, their merchandise, and yet neglect to insure their lives, surely the most important of all to their families, and more subject to loss*" Frankly, the authors have never found a source citation for the quotation, but they don't see why a little thing like that should keep them from using it. No one has ever found a source citation for the quotation usually attributed to Voltaire, "I do not agree with a word that you say, but I shall defend to the death your right to say it"; but that doesn't keep proponents of free speech from using it.

was the Presbyterian Ministers' Fund, Philadelphia, founded in 1759, using a charter granted by William Penn. It continues to operate today. The Episcopal Corporation was founded ten years later

Between 1790 and the 1800's, five insurance companies were chartered to write life as well as fire and marine risks. As far as can be determined, only one of these, the Insurance Company of North America, 1794, wrote any life insurance policies at all—six in five years, all of them short-term life and pirate ransom contracts written at very high premiums and containing severe conditions and restrictions.

At the close of the eighteenth century, there were only 160 policies in force in the United States.

The first commercial corporation to write life insurance exclusively was the Pennsylvania Company for Insurance on Lives and Granting Annuities, organized in 1812. It wrote only a handful of policies but is credited with being the first American company to employ scientific principles in underwriting and rating risks. Today, with a simplified name, it confines its activities to trust operations.

The first life insurance selling agency in the United States seems to have been that of Israel Whelen, agent of the Pelican of London, who announced in newspaper advertising in 1807 that he was prepared to issue insurance on lives.

The Girard Life Insurance and Trust Company, a stock company organized in 1836 in Philadelphia, was the first American company to allow policyholders to share in profits. Its first dividend was distributed in 1844 in the form of paid-up additions to the face amount of the policy.

The New England Mutual, chartered in 1835, was the *first of the commercial companies still writing life insurance to be chartered*. However, New England Mutual did not issue its first policy until February, 1844. In the meantime, the Mutual Life of New York had been incorporated in March, 1842, and issued its first policy in February of the next year. It is *the first of the mutuals still in existence to write a policy*.

The first health insurer in the United States was the Massachusetts Health Insurance Company, Boston, established in 1847. The first accident company was the Franklin Health Insurance Company of Massachusetts, founded in 1850. It offered twenty-four-hour coverage for railway and steamboat injury. Injury carried compensation up to \$200; total disability was covered for two months for up to \$400; and the premium was 15 cents a day.

3. ELIZUR WRIGHT.

One of the outstanding personalities in the history of life insurance in America was Elizur Wright, an abolitionist who turned his crusading drive

toward life insurance after a visit to England where he attended an auction of existing life insurance policies.⁵

Since surrender values in a life insurance policy were rare, it was a common practice in England for old people who could no longer pay their premiums to offer their policies for sale.⁶ The buyer made himself the beneficiary of the policy and took over the premium obligations in the hope of eventually collecting more from the policy than he had put into it. At auctions where old policies were sold, the insured would "mount the block" to be inspected by prospective buyers who were interested in speculating on how much longer the policyholder would live, and hence how much they should pay for the policy. Usually, the price paid for the policy was only a fraction of its actuarial value.

This practice smacked so much of American slave auctions that it aroused the evangelical wrath of Wright. He returned from England later to become a lobbyist in the Massachusetts legislature for laws requiring nonforfeiture values in life insurance policies. Furthermore, Wright was convinced that reserves on whole life policies often were so inadequate that the solvency of the companies was endangered. He wanted a law establishing a state insurance commission which would calculate not only proper policy reserves but also would have the power to enforce these reserve liabilities upon the companies. In other words, he wanted what is called today a "legal reserve."

Wright calculated a monumental set of net reserve valuation tables which were adopted by Massachusetts in 1850 as a basis for judging the solvency of companies. In 1858 Wright was appointed as one of a two-man board of insurance commissioners.⁷ By 1861 he witnessed the passage of his nonforfeiture law by the Massachusetts legislature. While in office as insurance commissioner, Wright started and maintained a registry book in which he listed every single policy issued in the state together with yearly calculations showing what the reserve should be at any point. He kept this registry open to any policyholder who wanted to see what the reserve on his policy should be. He published financial statements of companies and kept the public informed generally on the state of the insurance business. In his eight years in office, Wright forced fourteen companies out of the state on the grounds of dishonest practices. Wright's capacity for irritating legislators, his candor, his constant barrage of questions about profits, expenditures, dividends, salaries, and his life insurance registry—all these and more kept the companies frantic, and irritated all who did not want sound practice and many who did. As a result, he was finally forced from office in 1867; but his labors had for

⁵ Wright was graduated from Yale University in 1826 and soon thereafter became a teacher of mathematics at Western Reserve College. His interest in the antislavery movement led him to abandon teaching in 1833 to go to New York to write for and edit abolitionist journals.

⁶ The Institute of Actuaries of Great Britain and Ireland later fostered a law on the assignment of policies which brought about the end of this practice.

⁷ The other member was G. W. Sargent, who was greatly overshadowed by Wright.

all time made their impression on the course of life insurance in America. His annual reports as commissioner had been carefully studied by insurance men in England as well as in America; and those reports, together with his mathematical computations, laid the foundation for the sound development of life insurance.

4. THE ERA OF ESTABLISHMENT.

The decade of the 1850's was notable not only for Elizur Wright and for the rise in life insurance sales but also for the establishment of modern marketing practices. In 1843 Morris Robertson, founder-president of Mutual of New York,⁸ broke with previous American life insurance marketing traditions and became one of the first important users of the agency system. His demonstration of the value of aggressive selling through personal solicitation was instrumental in making the agency system, in time, almost universal practice in American life insurance marketing.

As the value of the agent became apparent, companies began to treat agents more liberally by increasing commissions above the original 5 per cent and removing restrictions on their earnings, such as that placed by one company which required that an agent's earnings in excess of \$1,500 a year be reverted to the company. By the time of the War Between the States,⁹ the most common commission schedule called for 50 per cent of the first year's premium on a whole life policy and a renewal commission of 5 per cent for each of the subsequent nine years the policy remained in force.

The Decade of the Sixties. As might be expected, the Civil War brought the development of life insurance to a standstill. Northern companies had difficulties servicing Southern policyholders. Many claims were disputed. But contrary to predictions at the beginning of the conflict, the war did not bring disaster to the business.

In 1863 J. G. Batterson, Hartford architect, intrigued by the widespread practice in England of issuing a travel accident policy as an extra stub on a railroad ticket, established the Travelers Insurance Company. A year later the company decided to extend its coverage to more than travel accidents and had its charter amended to include all types of accident coverage. The establishment of the Travelers marked the beginning of modern accident insurance.

By 1866 there were sixty companies and associations in the accident insurance field, and competition was so intense that it was endangering the rate

⁸ This company (Mutual Life of New York) likes this shortening of its name. In the 1950's an advertising man discovered that the initials of the shortened form spell "MONY," which, for any advertising man, is near enough to "money" to make an advertising slogan for a company which deals in money.

⁹ The Southern background of one of the authors prevents his agreeing to the exclusive use of the term "Civil War." Therefore, there has been a compromise. In some paragraphs, the Civil War will be referred to as the "War Between the States." In others, the War Between the States will be referred to as the "Civil War."

structure. In 1865 Travelers chartered the Railway Passengers' Associations of Hartford and consolidated the ticket business of ten companies. Of the seventy companies organized between 1865 and 1869, only the Travelers was left by 1871. In 1878 it dissolved the Railway Passengers' Associations and transferred the business to its own ticket department.

Accident insurance received great impetus from the disasters of the decade following 1864. In 1864 alone, 140 railroad accidents took 404 lives and injured 1,846 persons. In the four years, 1867-1871, there were 526 steamship disasters in American waters that took 1,437 lives.

Claims arising from these disasters almost ruined the companies, but they were able to pull through with a certain amount of borrowing. The companies, however, capitalized on the publicity that made the public more accident-conscious.

Post Civil War. As soon as peace was declared ending the War Between the States, a period of general economic prosperity set in, and life insurance gained materially from it. From 1864 to 1869, for instance, premium income increased from \$16,163,138 to \$98,507,319 and assets rose from \$49,027,297 to \$229,097,425. One of the factors accounting for this increase was the abnormally high interest rate of about 30 per cent, which effected a reduction in the cost of insurance and made it possible to pay high commission rates.

Although the British Friendly Societies had found their way into America much earlier, it was not until 1868 that the first fraternal society was established in the United States. In October of that year, John Jordan Upchurch, a railroad master mechanic, organized the "Ancient Order of United Workmen." His motivating idea seems to have been to offer working men greater privileges than they found in the usual trade unions of that time. Included in the Upchurch program was a plan to provide members with protection for dependents cheaper than commercial companies were offering it. Unfortunately, Upchurch did not profit by the experience of the British Friendly Societies, but instead fell victim to the lures of the assessment principle, which had appeared earlier in the development of the life insurance business. Miles M. Dawson, referring to the experience with assessment plans, wrote some thirty-seven years later, "The subject . . . represents the pathological side, if I may express it, of life insurance."¹⁰

Upchurch's method of accumulating benefit funds was unsound, for there was no attempt at scientific rate-making. The plan called for the payment of \$1.00 by each member into the insurance fund. When a member died, his dependents were paid up to a limit of \$2,000 in death benefit out of this fund, and another dollar was collected from each member to prepare for the next death. This was a simple, pass-the-hat assessment plan. No reserves were accumulated. However, the idea of fraternalism appealed to the notoriously

¹⁰ *Annals of the American Academy of Political and Social Science*, XXVI, 1905, p. 120

gregarious nature of Americans, especially since it seemed like cheap insurance.¹¹ The A.O.U.W. became not only popular but also the inspiration for a multitude of other societies. Some of these societies, to make the plan more practical, changed the method of levying an assessment at each death to a plan of "flat assessments" at regular intervals, but invalidly uniform for all ages. After that followed the "graded assessment" plan, which varied the assessments according to age of entry. Nevertheless, all these assessment plans resulted in rates which were inadequate to provide funds sufficient to meet all obligations as the society membership grew older. The inevitable result was a high failure rate among such societies, which eventually led to the formation of the National Fraternal Congress in 1886. One of the first actions of the congress was to seek remedial legislation in the states relating to fraternal insurance. It actively sponsored a movement for a bill regulating the business and defining the status of fraternal societies. Known as the NFC uniform bill, it was submitted to the various state legislatures and passed by several of them. An amendment adopted in 1897 called for the creation of a reserve; and in 1899 the National Fraternal Congress Table of Mortality was adopted. In 1912 the New York Conference Bill was formulated, which is now generally the basis of fraternal regulation throughout the country.

Under the various insurance codes modeled after the New York Conference Bill, a considerable range is permitted in establishing solvency. Legal solvency and actuarial solvency, however, are not necessarily one and the same thing. Since theoretically all death benefits could be covered by assessments, a fraternal organization may be insolvent as measured by the standard for a legal reserve company and yet solvent as measured by statutory requirements.¹² It should be noted, however, that in the past fifteen years particularly there has been a trend among fraternalists to establish themselves on a basis which is actuarially as well as legally solvent. They handle their insurance transactions on the same basis as an "old line" company, differing from a mutual only in the fact that they have a lodge system.¹³

Since mortality cannot be less among the policyholders of a fraternal

¹¹ Competition between commercial companies and fraternalists was bitter. The assessment fraternal, not using the reserve system, could offer much lower premiums than the commercial companies. The term "old line," still widely used, came into being at this time. It was probably coined by the older commercial companies to emphasize the "old" and thus "tested." Some historians claim, however, the fraternalists coined it and that it was originally "old lyin'" companies—lying about the need for higher premiums. Professional critics of life insurance say the term refers to companies which persist in giving the public the "same old line."

¹² In order to be actuarially solvent, there must be a scientifically calculated reserve equal to the difference between the discounted value of future premiums and the discounted value of future claims figured on an adequate mortality table with conservative interest assumptions. If adequate reserves are not required, a company remains solvent as long as it can meet current claims; and in order to do this it must continue to grow with young policyholders.

¹³ The fraternal status does, however, carry district tax advantages for the company. In the larger fraternal companies, the aggregate of dollars saved runs high.

than among those of a regular company, it follows that if the test of actuarial solvency is to be met, rates cannot be markedly lower than those of the commercial companies. The narrowing of the margin of difference between commercial rates and fraternal rates, brought about by the trend of fraternal toward actuarial solvency and legal reserves, has lessened their special appeal as insurance carriers—apart from their appeal as social organizations. The proportion of life insurance in United States written by fraternal has dropped markedly from its peak in the earlier days when “rates” among the societies were set without relation to the scientific principles of rate-making.

The pressure after the Civil War among the old line companies and their agents for new business brought on new problems. The drive by the agents for commissions brought about less interest in renewals and more interest in new business. This encouraged high-pressure selling, misrepresentation, and “twisting.”¹⁴

To take advantage of the expanding and prosperous market for life insurance, many new companies were formed, too often on unsound bases so that with the coming of the panic of 1873 and the ensuing hard times, there was a high incidence of company failure.

The accident insurance business also ran into trouble in the '70's. The original simple policies had now, because of adverse court decisions, become highly complicated and hedged with all sorts of restrictions. Unscrupulous promoters, interested only in long profits, were sharp in their claim practices. Discriminatory legislation had reached harmful proportions. Heavy license fees were often imposed on out-of-state carriers; and state laws forced too much investment in weak state bonds.

Yet in the period from 1870 to 1890, the business was beginning to find itself. A number of strong companies were formed, and right at the end of the period, in 1891, Aetna Life opened an accident department.¹⁵

While, as noted, there was activity in the sickness insurance field as early as 1847, all the early insurers failed or expired, leaving nothing on which to build. For all practical purposes, the development of sickness insurance began in the 80's. The mutual associations led the experimentation in sickness coverage, beginning about 1885. In 1890 the St. Lawrence Life Association issued a combination accident and sickness policy, and in 1891 the Federal Life & Casualty, Chicago, introduced a similar form.

¹⁴ Twisting is the giving of untrue information about existing policies in order to encourage clients to drop these policies and take new ones. Commissions on new policies were well in excess of renewal commissions. Many “trades” were in evidence where agents exchanged clients and practiced the “twist.”

¹⁵ The health business was pioneered principally by casualty insurance companies. For example, one of the earlier insurers was the Knickerbocker Casualty Company, 1876, renamed Fidelity and Casualty Company of New York in 1883 and a leading company to this day.

5. THE ERA OF FRENZIED FINANCE.

From about 1870 on, the line of cleavage that had always been apparent between companies operated exclusively for the benefit of the operators and those operated with a sense of trusteeship became increasingly wide. Elizur Wright, now 64, began a fifteen-year battle to get legislation to drive the "brigands" out of the business.

A variety of strange, new practices came into the life insurance business. Tontine, which had swept France, Holland, England, and certain German states a century before, was revived in a modified but, as Wright saw it, equally vicious form.¹⁶ Among other objections, he foresaw that Tontine "kitties" would build up huge sums of money which might tempt companies with a weak sense of ethics to investment speculation.

Tontine was but one of the evils of the business in this period. There was trickery in company management. Other transactions among those companies on the misty side of the cleavage line related to questionable high finance. Loans were made to banks in which insurance company trustees were interested; concealed loans were made to state commissioners; a state commissioner was paid \$3,000 to foster a bill to crush the smaller rivals of one large company; lobbying reached such proportions that in one instance \$60,000 was paid to a lawyer for "work" in the state capitol of New York—and there being few regulations regarding the accounting practices of companies, the expenditure was carried on the books as "taxes." Newspapers were offered (and many accepted) a dollar a line to publish attacks on Elizur Wright, who was constantly goading the companies with prophecies of disaster. Nepotism of the worst order was rampant, and in the 1870's and early 1880's financial buccaneers repeated in America all the most unsavory details of the English bonanza days. Among agents there was widespread rebating, misrepresentation, and twisting. Those companies that stuck to conservative ways and ideals of trusteeship were sneered at, abused, and assailed when they dared speak out, and were forced into setbacks from which they did not recover for years.

Beginning of Trouble. In 1880 the trouble that was to result in the Armstrong investigation twenty-five years later began. The Tontine bubble broke. Over 100,000 policyholders had dropped their policies, and thousands bombarded the companies in person and by mail. Treated to the high-handed dismissal of their complaints, many instituted suits against the companies.

¹⁶ The tontine system used in the United States put a fixed amount into a "kitty" each year. Those maintaining their policies in force and living to the end of the Tontine period shared the "kitty." Those who dropped out or died did not. Hence, the fewer remaining to the end of the Tontine period, the bigger the share of each survivor. Shepard Homans, compiler of the American Experience Table of Mortality and one of the great actuarial names in life insurance history, is credited with developing the American Tontine plan; and D. Parks Fackler, still another actuarial great, described it in glowing terms as "the staff of life," providing increasing security as age advances.

They found no redress in law, for in the absence of insurance regulations to the contrary, the courts were forced to hold to the terms of the Tontine contracts. Public ill will, a feeling that "something ought to be done," faced the companies.

Overextension abroad, questionable financial transactions, and heavy lapsation¹⁷ weakened the position of the companies to the place where what had been easy morality in the annual statements of many companies became serious prestidigitation. Perjury in reports became a "smart trick," a sign of dexterity. A variety of subsidiary financing brought companies into the field of investment banking. In the end, the whole sorry mess in the life insurance business was forced on the reluctant New York legislature by a terrific internal battle for the control of one of the major New York companies.

Although the health insurers were not caught up in the New York investigation, conditions in that field were not good, either. Policies were restricted and filled with complicated clauses. There was little or no co-operation among companies to improve conditions in the business in general.

Legal requirements were lax, and so was supervision. Competition, as in the field of life insurance, was cutthroat. There was little constructive thought or vision for the future. Accidental death policies of up to \$150,000 on one life were issued without adequate underwriting, and monthly indemnities totaling well beyond the bounds of good underwriting practice were assumed.

In disability insurance the period was not wholly one of trouble. It saw the spread of insurance against sickness. In 1897, the stock companies began to write sickness coverage, Fidelity & Casualty leading by introducing a conservative combination accident and sickness policy restricted to about fifteen specified diseases and containing a seven-day waiting period and twenty-six-week benefit provision.

By 1900 the accident and sickness form had broadened. In 1903 all excluded diseases were eliminated and surgical benefits added. Step-rate premiums were abandoned for a flat rate with an increase between 51 and 60. By 1908 the seven-day waiting period had been generally dropped by most companies, questionable progress to say the least.¹⁸

6. THE ARMSTRONG INVESTIGATION.

On July 20, 1905, the New York legislature, in accordance with a resolution adopted by the respective bodies, established a joint Senate and Assembly committee to investigate the life insurance companies in the state.¹⁹ Accord-

¹⁷ In 1895 the net gain in insurance in force for the year was one-eighth of the new business written.

¹⁸ Waiting periods exclude the small losses, and therefore are desirable from the viewpoint of good insurance theory. Cf. Chapter 2

¹⁹ "The committee shall . . . proceed to investigate and examine into the business and affairs of the Life Insurance companies doing business in the State of New York, with reference to the investments of said companies, the relations of the officers thereof to such investments, the relation of such companies to subsidiary corporations, the government and control of such companies, and any other phases of the Life Insurance

ing to the resolution, the appointment of the committee stemmed from the conclusions in the preliminary reports on a major New York company. These reports indicated that policyholders and their beneficiaries were not being properly safeguarded by existing laws and that a review of the insurance laws of the state was necessary because of the limited power of the Superintendent of Insurance. The Superintendent's powers were limited to examination with the chief view toward assuring solvency, whereas the reports indicated the necessity of investigating the companies more fully. The committee was organized on August 1, 1905, and began public hearings the following September 6. It continued in session consecutively for fifty-seven meetings, closing on December 30, 1905. The committee became known as the "Armstrong Committee," and hearings were conducted by a brilliant counsel, Charles Evans Hughes, later to be Chief Justice of the United States Supreme Court.

The committee found even more than it had expected. Chicanery, manipulation, unholy alliances, squandering of funds stalk like nightmares through the seven aging volumes of testimony and exhibits known as *The Armstrong Report*.

Committee Findings. The Armstrong investigation centered around four phases of the business: regulation, investments, expenses, and dividends, and its findings can be summarized as follows:

(1) *Regulation.* Directors and trustees were failing to serve as a check on management, their committees acting as mere "yes men" to officers. Policyholders, who are the theoretical control of mutual companies, actually had no voice in management. The committee recommended that these conditions be corrected.

(2) *Investments.* Some companies were doing a banking business through ownership of bank stocks and were generally guilty of carrying uneconomically large balances with such banks. Still other companies were selling securities as investment bankers for industrial corporations. Many life insurance companies were holding real estate illegally and constructing extravagant home office buildings. The committee recommended that investment in stock be prohibited and investment banking operations by life insurance companies be discontinued.²⁰

(3) *Expenses.* The committee found widespread extravagances. They felt that commissions to agents and salaries to officers were too high and that too much money was being spent on lobbying. The committee recommended a limit on acquisition expenses (the amount spent to put new business on the books) and on total expenses, and that lobby expenditures be reported in detail.

business deemed by the committee to be proper, for the purpose of drafting and reporting to the next session of the legislature such a revision of the laws relating to Life Insurance in this state as said committee may deem proper." *Concurrent resolution adopted by the Senate and the Assembly of the State of New York, July 20, 1905.*

²⁰ New York now permits some limited investments in stock. Cf. Chapter 22.

(4) *Dividends*. The committee opposed deferred dividends (an adaptation of Tontine), holding that the system built up huge surpluses which contributed to waste and extravagance. It recommended that annual dividends be required.

Result of the Report. A committee on Uniform Legislation (the Committee of Fifteen) was appointed by a conference of governors and insurance commissioners in Chicago in 1906 to study methods of strengthening insurance regulations. The New York Insurance Code of 1906, a result of the work of this committee, included just about all the recommendations of the Armstrong Committee and set the pattern for all state regulation throughout the country.²¹

The final result of the investigation was not only strengthened legislation but also a general housecleaning in the life insurance business. In the end, the most staunch advocates of the reforms that came from the Armstrong investigation were the life insurance companies themselves. In 1906 the institution of life insurance reached maturity. It soon found itself in a position of public confidence and stability from which it could advance, unhindered by irresponsible, self-seeking management. Those companies which had held to the line of the trusteeship concept throughout the era of Frenzied Finance were vindicated.

Never before nor since has the business been subjected to as searching an inquiry and examination as the Armstrong investigation—nor one as beneficial to its future welfare and development.

7. FROM THE ARMSTRONG INVESTIGATION TO WORLD WAR I.

The first effect of the Armstrong investigation was to decrease business in force, but this result was only short-lived. From 1900 to 1925 the number of companies in the country increased 364 per cent and the amount of insurance in force, 737 per cent. In 1900 only twenty-four states had life insurance companies domiciled within their borders. By 1925 there were domestic companies in all except two states.

The years from the Armstrong investigation to World War I also were a period of growth in the health insurance business. Disability provisions were extended from 26 to 52 to 104 weeks. Then, in 1913, Fidelity & Casualty introduced lifetime disability.

Non-cancelable, guaranteed renewable policies were introduced in Jan-

²¹ Not only does the New York Code set a regulatory pattern for the country, but also it has an extraterritorial effect, for it requires that any company licensed to do business in the state, whether New York domiciled or not, "substantially comply" with the New York code, especially in matters of acquisition costs and agents' commissions, in its operations in all other states in which it does business. Admission of a company to do business in the state of New York is still considered to be almost conclusive proof of stability and sound operation. Not one dollar of investment in life insurance was lost in the great depression of the 30's by the policyholders of companies licensed in New York.

uary, 1907, by the National Masonic Provident Association. The Pacific Mutual Life followed suit in 1915—which was the beginning of a period in which life insurance companies were highly active in the health insurance field and, as it turned out, were storing up serious trouble that broke out a little more than a decade later.

Many new health insurance carriers were formed in this period. In addition to the entrance of many life companies into the field, there came the rise of companion casualty companies for existing fire insurance carriers. Perhaps the most progressive step of the period was the introduction of the Standard Provisions laws in 1911.²²

8. WORLD WAR I.

The first interruption in the life insurance business following the Armstrong investigation was World War I, 1914–1918. The interruption is now generally considered to have been a stimulus to life insurance both because of the creation of war risk insurance, which introduced millions of soldiers to life insurance for the first time and raised their sights from \$1,000 policies to \$10,000, and also because of the period of prosperity that lasted virtually uninterrupted through the 1920's.

The war did not reflect unfavorably on the mortality experience of life insurance. Military death rates were not too high; companies had proportionately little in force on the young men who made up the armed forces; and war exclusion clauses were included in new policies issued during the period of hostilities.

However, in the health insurance field, lack of foresight during the early years of the century, when large single policies were written, unsoundly high monthly indemnities insured, and war exclusion clauses over-looked, caused World War I to throw the business into doldrums which lasted throughout the prosperous 1920's. This period of doldrums was made even worse by the fact that the business had not foreseen the growth of the automobile hazard in the earlier years of the 1900's.

About the most that can be said for the period from the entrance of the United States into the war in 1917 to the coming of the great depression of the 1930's is that there was a trend toward adaptability and some attempt to meet the needs of the public. Casualty and monoline health insurance companies were also affected competitively by the heavy activity of the life companies in the disability field through the writing of disability income riders on life insurance policies, usually providing \$10 per month per \$1,000 of face value in event of total and permanent disability.

Immediately following World War I, the United States was struck with the world-wide influenza epidemic, which was of plague proportions. There were over 450,000 deaths in the United States alone, and insurance company mortality increased 50 per cent to 100 per cent. Moreover, the greatest in-

²² Cf. Chapter 11.

crease in mortality was among young policyholders whose policies had not yet built up substantial reserves, and many companies had to draw heavily on contingency reserves, thus demonstrating the value of such reserves, which had often been criticized as unnecessarily large.

9. THE GREAT DEPRESSION.

In October, 1929, the New York stock market crashed. The effect on new life insurance sales was not felt immediately, but loan and surrender calls on existing policies started upward. As the general economic depression lengthened and deepened, loss of old business through policy termination and surrender accelerated, and by 1933 new business had been materially reduced.²³ When the attitude of the public toward all financial institutions indicated the possibility of a "run" on cash values similar to the "runs" then harassing banks, the various insurance commissioners instituted temporary restrictions on the companies in the payment of cash and loan values. Such payments, however, were never completely stopped, and maturity benefits, disability incomes, and supplementary contract incomes were paid as usual except, of course, during the bank holiday when all normal facilities for money transactions were shut down.

Depression factors which hurt the life insurance business most were decreased interest earnings and increased mortgage defaults. The amount of property held on foreclosed mortgages continued to be a problem to the life insurance companies until World War II, when a vastly increased demand for real property enabled companies to reduce their holdings markedly. Declines in the value of corporate stocks and failure of corporations had little investment effect on life insurance companies because stock investments had, since the Armstrong investigation, been limited by law.

Suicides went up—an increase of 30 per cent; but even more costly was the increase in claims under the disability income provisions so widely written into life insurance policies during the 1920's and under health insurance policies providing loss-of-time benefits. There was widespread exaggeration of the extent of disability, and court tests resulted in many a judicial interpretation of policy provisions that underwriting had never contemplated. The back of the non-cancellable health insurance business was broken, and life insurance companies experienced serious problems with total and permanent disability income riders. All but a handful of companies ceased writing these forms.

The life insurance business was able to come through the depression with an enviable record of investment safety. This record was partly the result of the traditionally conservative investing of life companies, partly the result of a diversified investment risk, and largely the result of the fact that company cash income kept coming faster than cash calls.

²³ In 1929 the total insurance in force in the country had topped \$100,000,000,000. In 1933 it receded below that mark and continued to decline until 1935.

There were life insurance company failures during the depression,²⁴ but most of them were reinsured by other companies so that the total loss to policyowners, percentagewise and in comparison with the field of general investments, was negligible.²⁵ The depression gave the institution of life insurance an opportunity to meet a difficult test with spectacular success and to prove the soundness of its structure.

Social Security. One of the important developments of the depression years was the Social Security Act of August 14, 1935. It contained a system of retirement benefits for workers in certain designated classifications, to be financed by a special payroll tax levied on both employees and employers.

In 1939 the original act was amended to add a system of benefits for widows and dependent children. In 1956 the act was amended to provide disability income benefits. Some people will argue that none of these benefits is insurance either in an actuarial or a practical sense.²⁶ Actuarially, the benefits are not adequately funded. In a practical sense, OASDI is not insurance because the covered worker has no vested or contractual rights. What he will get from the system and under what circumstances depends on legislation and not contract. The OASDI portion of the Social Security Act has been changed a number of times since 1935. The formula for calculation of benefits has been changed; benefit rates have been increased; new classes of employment and new benefits have been added. Such changes can be expected throughout the future inasmuch as Social Security and politics seem now to have become Siamese twins.²⁷

Hospital Insurance. Perhaps the most important development in the health insurance field during the depression years was hospitalization insurance. To the public, the depression dramatized the cost of hospital and medical care. This fostered the development of hospitalization insurance springing from prepayment plans fostered by hospitals in an attempt to fill empty beds.²⁸

²⁴ In the light of hindsight, it is possible to argue that some of the failures were unnecessary. In several instances, regulatory authorities seem to have stepped in too quickly to close up a company on a rigid test of liquidity on the basis of actual market values of its investments when, because no company is ever called upon to turn all assets into cash at once, it might have ridden out the situation.

²⁵ Company failures involved less than 3 per cent of the total life insurance in force. In a number of instances, death claims were paid in full in even these cases, confining any loss to impairment in cash values. See M. A. Linton, *Life Insurance Speaks for Itself*, New York, Harper & Brothers, 1937.

²⁶ That is, they do not meet the requirements for insurance as set up in Chapter 2 of this text. If it can be argued that social insurance does not have to meet the tests set up, then it might be possible to contend the benefits are "insurance."

²⁷ This comment is not to be taken as an indication of the attitude of either author on Social Security. It is simply a recognition of the fact that increasing Social Security benefits has come to be looked upon as "smart politics."

²⁸ There is at present severe conflict between regular insurance carriers and the Blue Cross and Blue Shield hospital-sponsored "insurance" plans, both of which provide prepayment of hospital and medical care. Nevertheless, the hospital plans led the way in the field of hospitalization coverage. The conflict today arises, among other things, from the

TNEC Investigation. Beginning in 1938, a Congressional committee, the Temporary National Economic Committee, commonly called "TNEC," undertook a study of the life insurance business with particular reference to monopoly power.²⁹ While the final report of TNEC called its investigation of life insurance the "most extensive study since the well-known Armstrong investigation,"³⁰ the investigation was not undertaken because of trouble within the business, as in the case of the Armstrong investigation, but as part of the TNEC's over-all study of concentration of economic power.

While starting out merely to study the relationship of the funds of life insurance companies to their use as an instrument of economic power, the investigation eventually went far afield, covering such unrelated ground as agents' training and compensation; comparative rates and costs of industrial, ordinary, and savings bank life insurance; annuity reserves; and technical operations.

Final recommendations of the TNEC committee regarding life insurance dealt largely with the need for strengthening of state supervision; for better qualification, training, and methods of compensating agents; for prohibiting a company from soliciting business by mail in a state in which it is not licensed; and for prohibiting intercompany agreements that reduce competition.

10. WORLD WAR II TO PRESENT.

World War II brought no setback to life insurance. New business exceeded prewar figures in every year except 1942, the first full year the United States was in the war. Between 1942 and 1945, inclusive, the total life insurance in force rose from \$130,332,848,315 to \$155,722,777,547.³¹

Unlike World War I, when war mortality showed little or no increase, World War II had a serious mortality effect. War-caused deaths between 1940 and 1945, not excluded by military-service riders or covered by extra

successful effort of Blue Cross and Blue Shield to have themselves thought of as a "community service" instead of insurance carriers. The ability to "sell" themselves as a "community service" often results in the various Blue Cross plans obtaining the use of prominent names in a community, and, in some instances, getting community leaders and organizations to go out and sell Blue Cross policies as a public service. It can be said either that the ability of Blue Cross to get such free services is good salesmanship on its part or that it is unfair competition, depending on which side of the fence one stands.

²⁹ The study was conducted by the TNEC for the Securities and Exchange Commission which was, at the same time, studying other allegedly monopolistic institutions, such as public utilities.

³⁰ While it is generally conceded that Hughes conducted the Armstrong investigation on a basis of strict impartiality, seeking to find facts whether unfavorable or favorable, some observers charge the TNEC investigation was conducted "in an atmosphere of antagonism to the companies." Cf. J. B. Maclean, *Life Insurance*, New York, McGraw-Hill Book Co., 7th ed., 1951, pp. 559-61.

³¹ The job of the life underwriter was facilitated by (1) increased national income, (2) decreased goods and services upon which to spend this income, and (3) rationing and price control of vital necessities, all of which meant more money available to buy life insurance.

rating, amounted to over 7 per cent of all death claims.³² However, because of extremely favorable civilian mortality experience during the same period, few companies showed an increase in total mortality rates.

The war did, however, have a direct effect upon the cost of life insurance. The greater part of all investments during the war period was in government bonds, which bore a lower rate of interest than available on other investments. The result was an acceleration of the already downward trend in interest earnings of life insurance companies, which meant an increase in cost to policyholders.

National Service Life Insurance. Starting in 1939, companies again began issuing policies with riders waiving the hazard of war-incurred deaths. To cover the hazard of war death, the federal government again made insurance available to servicemen. Written originally as five-year term (with the term period subsequently extended), this insurance (commonly known as "NSLI") was available to all servicemen up to a maximum of \$10,000, convertible any time after one year to one of several forms of permanent insurance.

At the end of 1944, the total servicemen's life insurance in force was \$123,754,000,000, rivaling the total commercial insurance in force in United States companies at the beginning of the war (1941: \$124,673,237,570). However, at the end of the first full year after the war, despite strenuous efforts of the government to keep NSLI in force, the amount of servicemen's life insurance outstanding declined to under \$37,000,000,000.

Upon the outbreak of the Korean War, the government substituted for its insurance system a gratuitous indemnity program for members of the armed forces. It was the thought that a gratuitous system would be less expensive to administer and would certainly meet with less objection from life insurance companies. The new plan, known as the Servicemen's Indemnity and Insurance Acts of 1951, did not replace the government insurance then in force but provided free indemnity of \$10,000 for the death of any person on active duty with the armed forces.³³ Protection was extended for 120 days following separation from service. The veteran within these 120 days may apply for a five-year nonconvertible but renewable term policy which will be issued nonmedically on a nonparticipating basis. Disabled veterans may obtain on a nonparticipating basis any policy form, permanent insurance included, offered under the amended NSLI act of 1940. The current status of NSLI is discussed in Chapter 24.

The Guertin Legislation. Throughout the 1930's the depressed economic condition made the public receptive to any type of criticism of business. One of the points that made best-selling articles, and even books, was

³² Causes: greater number of military deaths than in World War I, far greater number of men and women in service, much greater ownership of life insurance among service personnel—partly because of greater use of life insurance and partly because of older draft ages.

³³ From this \$10,000 were subtracted any NSLI or USGLI benefits payable.

the use by insurance companies of the American Experience Table of Mortality. This table had been compiled in 1863, reputedly on the experience of one company. Medical advancement throughout the twentieth century has greatly reduced infant mortality and mortality at younger ages, resulting statistically in an increase in the average length of life (life expectancy). Thus life insurance company reports were constantly showing mortality far under estimations in the table, as much as 50 per cent under in the case of relatively young companies and 25 per cent or even more in the case of older companies with older policyholders. The implication—and often the statement—of criticism was that the gain in mortality was an illegitimate profit to the companies and that the rates were excessive.

As a result of this criticism, the president of the National Association of Insurance Commissioners appointed a committee in 1937 to study the need for a new mortality table and related matters. The chairman of the committee was Alfred Guertin, then actuary of the New Jersey insurance department; his committee subsequently became known as the “Guertin Committee”—and legislation based on the committee recommendations as “Guertin legislation.”

The committee constructed two new mortality tables and made recommendations for standard valuations which, in effect, broke the illusion that Elhuzur Wright had started that cash values are a mathematical equivalent of the individual policy proportion of the reserve.

The Guertin Committee recommendations were embodied in model legislation, which by 1950, had been passed in all states. The changes required by the Guertin legislation, as adopted in the several states, were extensive as far as the actuarial departments of home offices were concerned. Their overall effect upon the life insurance product itself, the policies each company issues, was negligible from the buyer's point of view. The use of the CSO basis of mortality brought about some adjustment in rates, particularly at earlier ages where mortality gains had been heaviest, and nonforfeiture values at several ages.

A new mortality table, the 1958 CSO, was later developed. The factors leading to the development of this table are discussed in Chapter 20.

Insurance and Interstate Commerce. Another development of the World War II years (1944) was the Supreme Court's reversal in the SEUA case of its seventy-five-year-old holding that insurance was not commerce and that therefore it could not be interstate commerce. This Supreme Court decision had little effect on life or health insurance, except that it exposed it to possible future federal regulation.³⁴ The question of state vs. federal control of insurance is deferred to the next chapter.

³⁴ In the fire insurance business, however, rates had been set for all companies by a rating bureau. In many states, the law recognized only the rates set by such bureaus; yet under the anti-trust laws, such action constitutes restraint of trade. The conflict between the requirement of state laws and the federal anti-trust law created a condition so

Mass Selling Developments. The war years also fostered the rise of mass selling techniques in life and disability insurance as contrasted to the sale of individual policies by agents. Tax laws, giving favorable treatment to group insurance premiums paid by employers, cost-plus government contracts, greater consciousness on the part of business management for good industrial relations, and union demands caused group insurance to skyrocket. Where this particular trend leads is still undetermined as this is written.

Health Insurance Developments. In addition to developments already mentioned, several others in health insurance deserve special attention.

The early 1940's saw the cautious re-entry of life insurance companies into the field of health insurance coverages from which they had almost all withdrawn after the debacle of the 1930's. Starting in the fifties, there was a rush to enter the health field. Over a period of approximately eighteen months at the start of the new decade, some fifty life insurance companies came out with a line of policies. Also, there was an increase in the number of companies writing disability income riders on life insurance policies.

From the mid-1940's on, there has been dramatic progress in the health insurance field. The Health Insurance Institute lists innovations since 1945 as introduction of polio and special risk coverage in 1946; accident insurance for school children in 1948; major medical in 1952; nursing and convalescent home expenses; congenital diseases in 1956; and drug costs in 1959. The 1960's are credited with starting off with dental care and cancer coverage (in depth, as contrasted to limited amounts in riders).

Other "new"³⁵ coverages of recent years have been overage insurance (that is, insurance on persons over age 65); group salary continuation coverage on a long-term basis (also known as "key man group"); conversion of group to individual in event of severance of employment or retirement; credit card insurance; association group for professional men; group overage hospitalization written on a statewide basis; and disability income with cash and extended term values. Certain forms of paid-up at 65 health insurance are appearing; and it seems reasonable to surmise that policies more suited to the "needs" type selling that is the general practice in life insurance will shortly appear in the health insurance field.

Some of the impetus for innovations has come from interest in the field by a "new generation" unseared by the experiences of the depression years; some from a desire to be of complete income insurance service; some from the necessity of finding ways to offset the effect on earnings of agents of lower average life insurance premiums and the inroads of group life insurance; some from the observable fact that health insurance is a "quicker" sale and thus helps get agents started financially with less subsidy from the com-

chaotic that it was necessary for Congress to pass emergency legislation declaring a moratorium until January, 1948, later extended to June, on the application of the Sherman and Clayton Acts to the insurance business.

³⁵ "New" in the sense of being relatively widely available.

pany; and a lot from a desperate attempt to cover the health insurance needs of the public so thoroughly that the federal and state governments have no justification on grounds of public need for socialized coverages.

There is no question but that the health insurance field will continue to expand even if there is government competition (as is the case in life insurance with Social Security) and that it could, conceivably in a decade or two, become the largest "line" of coverage measured by premium volume.

11. SUMMARY.

No summary has been prepared for this chapter. The chapter itself, covering over four centuries of life insurance history in less than a quarter of a century of pages, is itself only a summary.

QUESTIONS FOR CLASS DISCUSSION

1. Compare present-day policy restrictions with those found in the policies issued by the Society of Assurance for Widows and Orphans.
2. Why was the introduction of corporate underwriting in England so vigorously opposed by those in the insurance business?
3. What contributions to life insurance theory or practice were made by (1) the Amicable Society for a Perpetual Assurance Office, (2) the Society for the Equitable Assurance of Lives and Survivorships and (3) the Scottish Widows' Fund?
4. What United States insurance companies still in existence today can lay claim to the title of "first"?
5. In what ways has Elizur Wright influenced the life insurance business in America? Can you see any connection between the work of Elizur Wright and the work of the Guertin Committee?
6. From 1915 until 1953, the amount of fraternal insurance in force increased from \$9,444,000,000 to only \$9,913,000,000, whereas life insurance in force of all kinds increased from \$16,650,000,000 to \$186,710,000,000. How do you account for the fact that fraternal insurance did not maintain a dominant position on the American life insurance scene?
7. What was the status of the health insurance business in America at the time of (a) the Armstrong investigation and (b) the TNEC investigation?
8. Compare the nature, purpose, and results of the Armstrong investigation with the TNEC investigation.
9. Compare the effects of World War I, World War II, and the great depression on (a) the life insurance business and (b) the disability insurance business.
10. Compare United States Government Life Insurance of World War I, National Service Life Insurance of World War II, and Servicemen's Indemnity and Insurance of the Korean War. How do you account for the differences?

CHAPTER 27

The Regulation of Companies

Life insurance is one of the few American institutions engaged every day in operations that extend over three centuries. At any given time, life insurance companies are paying off contracts made in the last century while making contracts that may not be paid off until the next century.

Such long-range operations invite and require public regulation. Even if the majority of policyholders had confidence in their ability to keep constant watch on developments that affect the business, they would not have that same confidence in the ability of their beneficiaries to do so. It is natural, therefore, for them to seek what they consider the diligent and searching observance of public or governmental regulation.

Furthermore, insurance is a technical business, based on higher mathematics. Because of legal requirements, it is necessary to express the terms of insurance in complicated, legal phraseology which is incomprehensible to most laymen, and even to lawyers who are not specialists in the field. Since the buyer of insurance cannot hope to understand the technicalities involved, the judgment of technicians is necessary to keep constant watch on the business to prevent the companies from ill-advised attempts to take advantage of technical language to limit severely the coverage offered in a policy. Technicians also are needed to see that the companies maintain standards conducive to long-range solvency so that they will be in a position to deliver on their contracts when they mature.

For the individual policyholder to hire experts to provide these necessary technical services for him individually would be financially impossible even if insurance companies were willing to give the same co-operation to private examiners as they are required to give to state authorities. The natural solution was public supervision in the interest of the individual policyholder. As a result, the institution of insurance in both the United States and Canada is today under the surveillance of a complicated network of governmental—and occasionally political—supervision and control. In the United States especially, this regulation is complicated by the dual system of state and federal government authority.

1. THE HISTORY OF REGULATION.

While the history of modern insurance begins in England, the history of insurance regulation begins in the United States. Modern supervision of life

insurance had its beginnings in the establishment of the insurance department of Massachusetts in 1858, prior to which regulation consisted largely of restrictions and requirements in the charters issued by the states to the companies. The Massachusetts department was an outgrowth of the lobbying activities of Elizur Wright, who became a member of its original two-man commission. For Wright, the establishment of a state insurance department was but the first step in his dream of a "National Insurance Bureau" or "Interstate Valuation Commission."¹

Subsequently to the establishment of the Massachusetts department and the adoption of an insurance code in that state, the question of legislative regulation of life insurance came before the British Parliament.² Investigation revealed to the satisfaction of Parliament that while there were evils in the business,³ the degree of self-regulation being practiced by the companies was already more strict than anything the Parliament of the time would consider imposing by law. It pronounced as demagogic and dangerous any legislative interference with the business. However, in acquiescence to criticism, it did pass a law making it mandatory for companies to engage the services of an actuary to investigate their financial condition not less than once every ten years. The results of such "investigations" were to be set forth in a report published by the Board of Trade for the information of the public.

Currently, life insurance in the United States is regulated by the individual states. Each state has a department of insurance presided over by either an elected or appointed official, depending on the state.⁴ The department of any given state has jurisdiction over and regulates not only domestic companies, but also all foreign and alien companies licensed to do business in that state.⁵

¹ So convinced was Wright of the superiority of federal as contrasted to state supervision that he characterized the court decision in *Paul v. Virginia*, holding that insurance was not commerce and hence not subject to interstate regulation, as "a blow to the sound regulation of the business."

² As late as 1851, Old Equitable, with eighty-nine years of sound operation behind it, approached Parliament for a long-denied charter. It was informed that as an organization it was too ephemeral in nature to be granted the dignity of a charter.

³ Evils bitingly satirized by Dickens in the "Anglo-Bengalee Disinterested Loan & Life Insurance Co." of *Martin Chuzzlewit*.

⁴ Behind the mask of state authority are many faces. In forty-two jurisdictions, the head of the insurance department is called "commissioner"; in six, he is known as "superintendent"; in three, "director." One of these is a civil servant; ten are elected to office; forty are appointed. Thirty of the appointees serve at the pleasure of the governor; ten are appointed for a definite term. The numbers of their staff vary from five in Vermont to 638 in New York, but average sixty-five persons per department. The greatest number of employees are civil servants and have permanent status; but in many states, their tenure depends on the political fortunes of the commissioner. Insurance departments are financed by taxes, and budgets vary from \$30,000 a year in Alaska to \$4,600,000 in New York. The number of domestic and foreign insurance companies subject to their supervision averages 705 per department, varying from 273 for Hawaii to over 1,800 for Texas.

⁵ A "domestic" company is one organized under the laws of state in which it is

In Canada the business is subject to a dual system of federal and provincial control, both of which began at about the same time in the late 1860's. Conflicts and most of the duplication between the two systems have been adjusted in the past. The federal Insurance Department takes the primary responsibility for safeguarding the solvency of companies; whereas the provincial governments concern themselves primarily with the provisions of contracts, licensing of agents, and the regulation of general operations.

State Regulation. The pattern of state regulation of the business in the United States had its origin in the evolution of the political structure of the country. Originally, the regulatory activities of states in all areas exceeded those of the federal government. As early as 1866, however, a bill was introduced into the United States House of Representatives to create a national Bureau of Insurance in the Treasury Department. The Senate had a similar bill before it in 1868. One year later, the United States Supreme Court temporarily put an end to moves designed to bring about federal regulation of insurance. In *Paul v. Virginia*⁶ it held that "issuing a policy of insurance is not a transaction of commerce" and hence not subject to the interstate commerce clause of the federal Constitution even when insurance is written across state lines.

The case of *Paul v. Virginia* was, interestingly enough, not an attempt of the federal government to regulate insurance but of a fire insurance agent to escape state regulation. The Virginia law required that out-of-state companies be licensed by the state and, as a condition precedent to receiving a license, to deposit a given amount of securities with the state treasurer. Samuel Paul, a native Virginian, was appointed an agent in Virginia for a group of New York companies. He refused to comply with the deposit requirements and was, therefore, refused a license. Upon his continuing to transact business without a license, he was arrested, brought to court, convicted, and fined \$50. After the highest court of Virginia upheld the decision, the case was taken to the United States Supreme Court on the grounds that the Virginia law violated the constitutional requirement imposed on states to grant all the privileges and immunities of state law to citizens of all states, and that insurance was commerce and hence state regulation of a foreign insurer was interference with interstate commerce.

On the question of granting citizens of each state all the privileges and immunities of citizens in the several states, the court said that this constitutional provision was for the protection of human citizens and not corporate citizens which are creatures of state law only. On the question of the commerce clause, the court decided that issuing a policy of insurance is not a

being classified. A "foreign" company is one organized under the laws of a state other than the one in which it is being classified. An "alien" company is one organized in a country other than the country of reference. Thus, to a citizen of Illinois, an Indiana company is a "foreign" company and a Canadian company, an "alien" company.

⁶ 8 Wall, 183 (1869).

transaction of commerce within the meaning of the Interstate Commerce clause. The court had these interesting things to say on this point:

Issuing a policy of insurance is not a transaction of commerce. The policies are simple contracts of indemnity against loss by fire, entered into between the corporations and the insured, for a consideration paid by the latter. These contracts are not articles of commerce in any proper meaning of the word. They are not subjects of trade or barter offered in the market as something having an existence and value independent of the parties to them. They are not commodities to be shipped or forwarded from one State to another and then put up for sale. They are like other personal contracts between parties which are completed by their signature and the transfer of consideration. Such contracts are not interstate transactions, though the parties may be domiciled in different States. The policies do not take effect—are not executed contracts—until delivered by the agent in Virginia. They are, then, local transactions, and are governed by the local law. They do not constitute a part of the commerce between the States any more than a contract for the purchase and sale of goods in Virginia by a citizen of New York whilst in Virginia would constitute a portion of such commerce.

Hence, the *Paul v. Virginia* decision upheld the right of the states to regulate insurance and virtually closed the door on federal regulation for the next seventy-five years.⁷

Regulation Prior to 1906. As previously stated, regulation of the business prior to the establishment of the Massachusetts insurance department in 1858 and before the establishment of an insurance department in any given state was through corporate charters containing regulatory provisions. Usually, these provisions related to capital required, investments, and financial reports. Insurance companies were subject to the same type of regulation imposed on all monied corporations.

The incorporation of insurance companies by special act of the legislature was discontinued by a number of states by the middle of the nineteenth century in view of the formulation of incorporation statutes covering the various classes of carriers. Such legislation usually provided for reports of various kinds, but no special state official was designated to inspect such reports exclusively.

The step of selecting a special person or commission to examine insurance company reports, the next development in the history of insurance regulation, was taken by New Hampshire when it established in 1851 an ex officio commission for that purpose. Massachusetts in 1852 became the first state to provide specifically for the supervision of insurance and to appoint officials charged with that supervision. One of the earliest acts of the commissioners of Massachusetts was to establish standards of solvency for life insurance companies.

⁷ There were, however, some feeble attempts to introduce federal regulation. For example, in 1892 HR 9629, 52nd Congress, First Session, a bill for the creation of a federal office of Commissioner of Insurance was prepared, but failed to reach the floor of the House.

Many of the failures of life insurance companies in the decade from 1865 to 1875 may be attributed to extravagant, inefficient methods and, in some instances, dishonesty. However, many others may be attributed to strict enforcement by the new state insurance departments of requirements regarding valuation of reserves and valuation of assets. Thus, state regulation, while filled with inadequacies, had been actively and widely operating for thirty-six years prior to the Armstrong investigation in New York.

Results of the Armstrong Investigation. The Armstrong investigation in New York turned attention in almost all states and in Canada to the inadequacies of insurance regulation as practiced up to that time. As a result of that investigation, the State of New York passed a new insurance code early in 1906. This code, and subsequent amendments—still considered the most exacting among state insurance codes—furnished the pattern for all state codes since established or amended. It ran the whole gamut of management, officers, directorate, publicity and kindred activities, administration, and investments. For instance, it required an annual statement from each company on elaborate forms; the meeting of specific regulations concerning policy forms, valuations, etc.; the adherence to expense limitations; the observance of limits on the amount of new business;⁸ the regulation of dividends; the prohibition of stock holdings;⁹ limitations on the powers of officers; the insertion of nonforfeiture values and incontestability clauses; avoidance of practices resulting in nepotism; and limitations on agents' commissions. Every phase of the business, those mentioned and others, was covered by the code resulting from the Armstrong investigation.

Other states amended and strengthened their own codes to take advantage of the lessons taught by the New York investigation, resulting in a strong body of state insurance law throughout the country.

The National Association of Insurance Commissioners. A pronounced degree of uniformity in insurance laws has been achieved through the work of the National Association of Insurance Commissioners, to which each insurance commissioner in the United States belongs. This voluntary organization came about through the efforts of the second Superintendent of Insurance of New York, Hon. George W. Miller. In 1871 he saw the need for uniformity in annual statement reporting, examination practices, and laws, and invited the insurance commissioners of all the states to meet in New York. Out of this meeting came the present National Association of Insurance Commissioners, generally referred to as the N.A.I.C.

⁸ As explained in Chapter 23, acquisition costs usually exceed the first-year premium plus the establishment of the required first-year reserve. The extra money required is a drain on surplus. The more new business that is written, the greater the drain on surplus. However, on those occasions in the past when any New York company has reached its "quota" of new business prior to the end of the year, its surplus usually has been sufficient for the department to waive the limitation.

⁹ Amended in 1928 to allow investment in certain preferred and guaranteed stocks, and in 1951 to allow investment in common stocks to a restricted degree. Amendments in subsequent years have further liberalized the law.

Over the years, the N.A.I.C. has been welded into a highly constructive force. Although the full organization meets only twice a year, members in the various zones into which it is divided also meet at other times, and its various committees are at work holding hearings and conferences with representatives of industry and the supervisory authorities as often as need requires or circumstances permit. A subject for legislation is given thorough study, with industry representatives encouraged to state their positions frankly and at length, either individually or through industry committees. The result is a so-called model bill, which the commissioners are encouraged to present to their respective legislatures for enactment. Generally, state legislatures adopt these bills.

An idea of the scope of the work of the N.A.I.C. may be gathered from the following list of some of its standing committees: Life, Accident and Health, Blanks, Valuation of Securities, Examinations, Laws and Legislation, Preservation of State Regulation, Federal Liaison, etc. Currently its subcommittees number approximately twenty-five.

The first broad-scale investigation of the health insurance business was conducted in 1911 by the National Association of Insurance Commissioners. It resulted in the 1912 Standard Provisions law,¹⁰ concerned primarily with contract changes, policy reinstatements, notice of claim requirements, proof of loss requirements, time within which claim payments must be made, requirements as to whom benefits should be paid, and other administrative provisions.

Significantly, the Standard Provisions law, subsequently enacted in almost all states, did not restrict the companies from experimenting with new policy forms and coverages. It simply set up the "ground rules" under which the business should be conducted.

In addition to the Standard Provisions, state departments have general regulatory powers which typically prohibit unjust, unfair, inequitable, misleading, or deceptive policy provisions.

The SEUA Case. *Paul v. Virginia* stood for seventy-five years. It was tested time and time again, most often by insurance companies seeking to escape state regulation.¹¹ The power of the federal government specifically to regulate insurance was not tested in any of these cases. Then, on November 20, 1942, the South-Eastern Underwriters' Association, an organization controlling the rates for fire and allied lines in its territory, was indicted for violation of the Sherman Antitrust Act.

¹⁰ In 1950 the National Association of Insurance Commissioners developed a new model set of required provisions known as the "Uniform Individual Accident & Sickness Policy Provisions." All states now either require their use or permit it. Cf. Chapter 11.

¹¹ See, for example, *Hooper v. California*, 155 U.S. 658 (1895); *Noble v. Mitchell*, 164 U.S. 367 (1896); *Hopkins v. United States*, 171 U.S. 578 (1898); *New York Life v. Cravens*, 178 U.S. 389 (1900); *New York Life v. Deer Lodge County*, 231 U.S. 495 (1913); *Northwestern Mutual Life Insurance Co. v. Wisconsin*, 247 U.S. 132 (1918); *Bothwell v. Buckbee Mears Co.*, 275 U.S. 274, 276-77 (1927); *Colgate v. Harvey*, 296 U.S. 404, 432 (1935).

The charge against the SEUA ¹² was that it restrained interstate commerce by fixing and enforcing arbitrary and noncompetitive premium rates, controlling agents' commissions, and using coercion, boycott, and intimidation to force nonmember companies into the conspiracy by preventing them from obtaining reinsurance facilities.

Agents who represented nonmember companies were denied the right to represent member companies, and buyers of insurance from nonmember insurers were threatened with boycotts and withdrawal of patronage. The Association maintained a staff to police the agencies and companies.

The SEUA relied on the defense that since the Supreme Court had held that insurance was not commerce, the Sherman Act did not apply. The district court of Georgia upheld this view, pointing out that if the finding that insurance was not commerce were to be reversed, then the reversal would have to be by the Supreme Court which itself had established the ruling in 1869. The federal government then appealed the case to the United States Supreme Court.¹³

In a 4-3 decision, two justices excusing themselves from the case, the court held on June 5, 1944, that when the transaction of insurance business crosses state lines, it is interstate commerce.¹⁴ It explained that the business of insurance included many more operations than the issuing of policies, for it included "transmission of great quantities of money, documents, and communications across dozens of state lines," and these activities had been held in other decisions by the court to be a part of interstate commerce. Even the three dissenting justices agreed that Congress has the power to regulate insurance. Their dissent was based on the contention that Congress did not intend the Sherman Act to apply to insurance companies.

On the same day it handed down the South-Eastern Underwriters' decision, the Court held unanimously that a fraternal benefit society is subject to the National Labor Relations Act because it is an insurance company and its operations affect commerce.¹⁵ Had the United States Supreme Court in 1869 upheld the right of the State of Virginia to regulate the insurance business on the grounds "that states may regulate interstate affairs so long as they do not improperly burden interstate commerce, and so long as Congress has been silent,"¹⁶ it would have been spared the embarrassment of a reversal after having held steadfastly to an awkward decision for three quarters of a century.

Thus, in two cases decided about the same time, the court changed the ground rules established in *Paul v. Virginia* and opened the door to federal

¹² Made against about 200 of its member companies and twenty-seven individuals.

¹³ Fearing the impact of a reversal on state regulation, thirty-six states joined in opposing the appeal

¹⁴ 322 U.S. 533 (1944).

¹⁵ 322 U.S. 643 (1944).

¹⁶ Cf. annotations to U.S.C.A. Constitution, Article 1, Number 8, Clause 3, Note 1157.

regulation. It should be pointed out, however, that these decisions did not affect the power of the states to regulate the insurance business but simply nullified those state laws which were contrary to federal regulation.

The McCarran Act. Inasmuch as the laws of many states required the use of co-operative rate-making organizations in the fire and allied lines, the immediate situation was confusing since the SEUA decision made co-operative fixing of rates a combination in restraint of trade. In order for a company to comply with the state law, one had to violate the federal law, and vice versa. The resulting confusion as well as the sweeping implications of the SEUA decision made it obvious that many readjustments would be required. As a result, the McCarran Act¹⁷ was passed by Congress and approved on March 9, 1945.¹⁸ The McCarran Act did three things:

(1) In order to give the states time to enact the legislation necessary to bring state law into conformity with federal law, a moratorium period was established (originally until January 1, 1948, later extended to June 30, 1948) during which the federal antitrust laws would not apply to the business of insurance except as to boycott, coercion, and intimidation.

(2) It established that even after the expiration of the moratorium period, the federal antitrust acts should apply to the insurance business only "to the extent that the business is not regulated by state law."

(3) It contained a declaration that the continued regulation and taxation of insurance by the states is in the public interest and that silence on the part of Congress should not be construed as a barrier to state regulation or taxation.

Recent Developments. While Congress in the McCarran Act expressly recognized that the continued regulation by the states of the business of insurance was in the public interest, it also took steps to assure that insurance would be subject to fair trade laws. This was done by expressly making the federal antitrust laws applicable to any acts of boycott, coercion, and intimidation. The McCarran Act, however, also made these laws contingently applicable to insurance in all other areas by providing that the Sherman Act, the Clayton Act, and the Federal Trade Commission Act shall be applicable to the business of insurance to the extent that such business is not regulated by state law.

Congressional deference to state regulation in any areas of interstate commerce can be justified only as long as regulation by the states continues to be in the public interest. If it should ever become apparent that this regulation is deficient or otherwise does not best serve the public, Congress stands ready to assume the primary regulatory role. Insurance regulation by the states is, of course, no exception. It is thus to be expected that Congress,

¹⁷ Public Law 15, 79th Congress.

¹⁸ The insurance industry had previously sought to have Congress pass a law specifically exempting insurance companies from the federal antitrust acts.

through one of its appropriate committees, will periodically review and assess the quality and over-all effectiveness of state regulation of interstate insurance.

During the first decade after the passage of the McCarran Act, the states, under the leadership of the National Association of Insurance Commissioners, enacted laws to strengthen the regulatory role of the various state insurance departments. Since 1945 all states have enacted the "Model Unfair Trade Practices Bill for Insurance," or a substantially similar law. The Model Bill is the state counterpart of the Federal Trade Commission Act. In general, these laws empower the insurance commissioner to regulate, within the area of his jurisdiction, unfair competition and unfair trade practices in the insurance field, much in the same manner as the Federal Trade Commission regulates these practices in other fields.¹⁹ The states, generally, have also enacted Little Antitrust laws applicable to insurance, including prohibitions against interlocking insurance directorates which would substantially lessen competition. This development of the state trade regulatory laws, to parallel closely the Sherman Antitrust Act, the Clayton Act, and the Federal Trade Commission Act, was thought to be necessary under the express provisions of the McCarran Act to eliminate the contingent applicability of these federal statutes.

This generally accepted interpretation of the McCarran Act, however, was directly challenged by the Federal Trade Commission in 1954. In that year and during the following year, the Commission issued complaints against forty-one insurers, including many life companies, on the ground that the health insurance advertising of these companies was in violation of the Federal Trade Commission Act. The Commission thus sought to assume general jurisdiction over interstate advertising, despite the existence of the state regulatory laws covering this same subject.

The Commission's theory was twofold: The first argument was that the state laws could not by reason of the constitutional limitations against extra-territorial regulation effectively regulate advertising beyond its borders, thus leaving a vacuum in the regulation of interstate advertising that could be filled only by the Commission; the second argument was that the states and the Federal Trade Commission have concurrent jurisdiction in this area and

¹⁹ The National Association of Insurance Commissioners has long recommended implementation of these laws, wherever required, by administrative regulation. This self-surveillance of the effectiveness and adequacy of state regulation, through the offices of the N.A.I.C., has resulted in adoption by thirty-one states, up to this writing, of the N.A.I.C. "Rules Governing Advertising of Accident and Sickness Insurance." This N.A.I.C. code also served as the pattern for the Trade Practice Rules for Insurance Advertising subsequently adopted by the F.T.C.

During this period, forty-four states also enacted the "Unauthorized Insurers Service of Process Law." These statutes permit a policyholder to sue an insurer in the state of the policyholder's residence, even though the insurer has sold the policy through the mails and is not licensed to do business in that state.

that the one which first undertook to regulate, by entry of a cease and desist order, was the one which had ultimate authority.²⁰

In 1958 the Supreme Court unanimously rejected these arguments and dismissed the complaints against two companies involved, both of which were agency companies, licensed by each of the states in which they did business.²¹ Neither did any mail order business, and both confined their advertising largely to point-of-sale literature or brochures shown to the prospect by the local agent at the point of sale. The Court, in denying Commission jurisdiction, laid down the following criteria for determining the area of Commission jurisdiction over insurance advertising generally:

(1) The Commission's jurisdiction is limited to the advertising disseminated within those states (other than an insurer's domiciliary state) which have not enacted a regulatory law of the type contemplated by the McCarran Act. The Model Unfair Trade Practices Act or its equivalent was specifically found to be such a law. The Court also found that each of the then forty-eight states had enacted the requisite laws so that in the cases before it, no jurisdictional gaps remained and the Commission had no jurisdiction.

(2) Even though a state may have enacted such a law, the Commission has jurisdiction over the advertising disseminated within the borders of such state if there are any constitutional (due process) limitations on the state's authority to regulate such advertising.

Although the Commission immediately conceded that this decision ousted it of jurisdiction over companies that advertised locally in states in which they were licensed, or advertised only in the form of point-of-sale material used by its agents, it continued to assert jurisdiction over mail order companies and, for a while, over non-mail order companies which advertised in the so-called "mass media," such as radio, television, and national magazines. The theory was that in these two cases there were due process limitations on the states' authority which rendered the state laws ineffective, thus making applicable the stand-by authority of the Commission.

The Commission's assertion of jurisdiction over the mail order com-

²⁰ The Commission itself was split 3-2 on the matter of its jurisdiction. Two of the Commissioners took the position that, pursuant to the mandate of the McCarran Act, the enactment of state legislation in this area ousted the Commission of any jurisdiction in so far as non-mail order insurance was concerned. The Commission was unanimous, however, in its position that it had jurisdiction over the advertising practices of mail order companies on the theory that companies doing business by mail did not subject themselves to the jurisdiction of the states in which they solicited business and that the laws of those states could not by reason of due process and other limitations protect their citizens against misrepresentations reaching them through the United States mail (Commission decision of December 20, 1956, in *Matter of Travelers Health Assn. v. F.T.C.*, Docket 6252; subsequently approved by the Supreme Court, 362 U.S. 293 [1960]).

²¹ *F.T.C. v. National Casualty Co. and F.T.C. v. American Life Ins. Co.*, 357 U.S. 560 affirming 263 F.2d 719 and 246 F.2d 883.

panies was upheld by the Supreme Court in a 6-3 decision in March, 1960.²² The basis of the Court's holding was that the requisite state law, contemplated by Congress in the McCarran Act for ousting Commission jurisdiction, could not be found in a Nebraska statute which expressly prohibited a domestic insurer from engaging "there or elsewhere" in any unfair or deceptive act or practice in the conduct of the business of insurance.

The other theory, namely, that Commission jurisdiction over an insurance company depends upon the media of its advertising rather than the absence of a state's *in personam* jurisdiction over the company, was quickly rejected by the Commission itself.²³ The "mass media" theory had been advanced by Commission counsel on appeals taken by them to the Commission from recommended dismissals for lack of jurisdiction by the Commission's own Hearing Examiners. This rejection by a unanimous Commission of the so-called "mass media" theory means that the Commission's jurisdiction in this area is confined to the case of the non-admitted mail order insurer.

The F.T.C. was not the only federal agency during this period to seek a measure of jurisdiction over insurance. In 1956 the Securities Exchange Commission brought an action against the Variable Annuity Life Insurance Company of America (VALIC) and the Equitable Annuity Life Insurance Company (EALIC) to compel those companies to register their variable annuities with the S.E.C. pursuant to the Securities Act of 1933. These companies had been organized in 1955 and 1956 in the District of Columbia as stock life insurance companies and are licensed there and in several other states under the insurance laws pertaining to life companies. Their principal

²² *Travelers Health Assn. v. F.T.C.*, 362 U.S. 293, reversing 262 F.2d 241. The Travelers, a Nebraska mail order health insurance company, solicits in all states. It is licensed only in its home state of Nebraska and in Virginia. The key to the majority opinion is in the following excerpt:

"In our opinion the state regulation which Congress provided should operate to displace this federal law means regulation by the state in which the deception is practiced and has its impact."

While there is little in the Court's opinion to encourage state supervision of multiple state mail order insurance advertising, further activity in this field is to be anticipated. For example, still to be decided is whether general passage of state laws similar to the so-called "Model Unauthorized Insurers False Advertising Process Act" will be considered sufficient regulation by the state where the advertising has its impact to oust the F.T.C. This model act authorizes the Commissioner in such a state to issue a cease and desist order on his own motion and to levy fines up to \$5,000 for disobedience to such an order.

²³ In the *Matter of Mutual Life Insurance Co. of New York*, Docket 6450 (Final Order of March 4, 1959). This rejection was foreshadowed by the Supreme Court decision in *National Casualty*, *supra*, since the state where the advertising is read, whether that advertising be in a newspaper, magazine or agent's brochure, would clearly appear to have constitutional authority to enforce its laws against a company over which it has *in personam* jurisdiction. See *Wilburn Boat Co. v. Fireman's Fund Ins. Co.*, 348 U.S. 310 (1954); *Prudential Ins. Co. v. Benjamin*, 328 U.S. 408 (1946); *Robertson v. California*, 328 U.S. 440 (1946); *Osborn v. Ozlin*, 310 U.S. 53 (1940); *International Shoe Co. v. Washington*, 326 U.S. 310 (1945).

function is a special one, however, namely, to sell variable life annuities.²⁴

Since annuities and other insurance contracts are specifically exempt from S.E.C. jurisdiction by the Federal Securities Act of 1933 and the Investment Company Act of 1940, the principal question involved in this litigation was whether the variable annuity in the form offered by these companies is an insurance function within the meaning of these federal statutes, or whether it is a security transaction similar to that offered by a mutual fund.

The Supreme Court, in a 5-4 decision, reversed the Federal District Court and the Court of Appeals and held that the variable annuity as offered by VALIC and EALIC was a security and not "insurance" within the meaning of the insurance exemptions of the Securities Act of 1933 and the Investment Company Act of 1940.²⁵ While the implications of this decision are not yet wholly clear, it appears reasonable to conclude that the variable annuity companies will be subject to dual regulation by the S.E.C. and the state insurance departments. Whether S.E.C. jurisdiction will be avoided by any old line insurance company incidentally offering variable annuities with restrictions on surrender during the accumulation period and a reasonable balance between fixed-dollar and variable annuity payments is still to be determined.²⁶

Although the variable annuity is still an experiment as well as a source of controversy in the life insurance industry itself, it does clearly involve life contingencies, namely, the liquidation of the annuity consideration and the income thereon exactly over the span of life. The Supreme Court recognized this, but the majority of the bench felt that in the case before it, the absence of any guarantee that at least some fraction of the benefits will be payable in fixed amounts rendered the insurance element largely superficial.²⁷

²⁴ Discussed in Chapter 5 Both also offered, as ancillary and secondary features to the variable annuity, decreasing term life insurance on a short term basis. This decreasing term life insurance was not involved in the S.E.C. litigation.

²⁵ *S.E.C. v. Variable Annuity Life Ins Co., et al.*, 359 U.S. 65, 3 L Ed. 2d 640.

²⁶ For example, New Jersey in 1959 enacted enabling legislation for domestic life companies, such as the Prudential, to write variable annuities under segregated accounts (Chs. 122, 123 and 124, Laws of 1959, and Regulation No. I 1959A-2, N.J. Department of Banking and Insurance). Connecticut (Public Act 317 [1959]) authorizes domestic life companies to maintain similar accounts for pension benefits.

²⁷ Justice Douglas, a former S.E.C. Chairman, in speaking for the majority, said (p. 71):

"... we conclude that the concept of 'insurance' involves some investment risk-taking on the part of the company. . . . in common understanding 'insurance' involves a guarantee that at least some fraction of the benefits will be payable in fixed amounts."

Justice Brennan's concurring opinion, joined in by Mr. Stewart, acknowledged that while these contracts "patently contain a significant annuity feature," "administering them also involves a very substantial and in fact predominant element of the business of an investment company and that in a way totally foreign to the business of a traditional life insurance and annuity company, as traditionally regulated by state law." He then proceeded to view the question from the point of view of the purpose of the insurance exemptions in the two federal statutes. He concluded that while Congress clearly did not consider the disclosure and other purposes of the Securities Act as relevant or meaningful

Many believe that a variation of the contract involved in the VALIC case, namely, one in which the company underwrites a substantial part of the investment risk, may lead to a different result. This view is encouraged by the Court's recognition of life insurance as "an evolving institution," as well as the Court's assurance that it "would not undertake to freeze the concepts of 'insurance' or 'annuity' into the mold they fitted when the Federal Acts²⁸ were passed."

The year 1958 also saw the beginning of what may be expected to be periodic Congressional appraisals of the regulatory stewardship of the states. An investigation by the Senate Judiciary Antitrust Subcommittee, under the acting chairmanship of Senator Joseph C. O'Mahoney, continued during 1959 and 1960. The Subcommittee in its report charged that the administrative capacity of many insurance departments is inadequate, and control over many insurance operations is lax and ineffectual. Also, in numerous instances, states' statutes are too weak to guarantee effective regulation. The committee made various recommendations to correct these situations. The report charged that state regulation of both aviation and air travel insurance has been completely ineffective in eliminating the restrictive market practices discovered by the Senate Subcommittee. The report recommended that if the Justice Department is powerless to combat these restrictions, it may then be necessary for Congress to consider appropriate revisions of the laws.

The report did not recommend any immediate changes in the McCarran Act. It did, however, suggest the possible need of amendments in the future, if, after the states are given further opportunity to improve their systems of regulation, it is conclusively shown that neither the states nor the federal government can prevent or reach abusive practices which otherwise would be construed as violation of the antitrust laws.

In 1958 Congress enacted legislation in the employee pension and welfare area. After more than four years of investigation into alleged abuses in this field, both in the area of self-administered, including trusteed, plans and those provided by group insurance, Congress passed the Welfare and Pension Plans Disclosure Act.²⁹ Its purpose is to compel disclosure and reporting of the various details of every employee pension or welfare plan covering more than twenty-five employees.³⁰ In addition to coverage details, such things as commissions, the persons to whom they are payable, and fees for the installation and administration of the plans are required to be made matters of public record. It also required disclosure of employer and employee contributions,

in so far as traditional insurance and annuity concepts are concerned, it did not intend for this exemption to be extended to this new form of contract which, although labeled annuity, placed so much emphasis on the changing state of its investment portfolio.

²⁸ The Securities Act of 1933 and the Investment Company Act of 1940.

²⁹ 29 U.S.C.A. §§ 301-9.

³⁰ The employer must, of course, be "engaged in [interstate] commerce or in any industry or activity affecting commerce." Or if a union has established the plan, the union must represent "employees engaged in commerce or in any industry affecting commerce."

claims, and dividends paid. The statute is not a regulatory law, and it provides neither standards for such plans nor sanctions for any abuses. Its purpose is to compel disclosure so that force of employee and public opinion will operate to contain such abuses as mismanagement of investments or unsound actuarial assumptions in self-administered plans,³¹ kickbacks, excessive service fees, switching, contingency commissions,³² and other drains on the funds available for employees' benefits. The abuses that were uncovered by the Senate and House investigatory committees were for the most part confined to union-employer, self-administered plans, although some segments of the insurance industry were not wholly blameless.³³

It is largely because the legislation contains neither standards nor government sanctions for abuses in this field that the act has been criticized in many quarters. Indeed, then President Eisenhower, in approving the law, stated he did so "because it establishes a precedent of federal responsibility in this area," even though "it does little else." The President prophesied at the time that "if this bill is to be at all effective, it will require extensive amendment at the next session of the Congress."

In theory, however, the federal legislation is not wholly unworkable. If the responsibility for setting up detailed regulatory standards in this area and the erection of penalties for their violation is left to the states, the co-operation between the federal act of disclosure and the state laws providing penalties for disclosed abuses may well prove to be wholly workable. While, to the extent that pension and welfare plans are funded with insurance, this is another experiment in dual regulation of a segment of the insurance industry, it is one where in the long run there need be no conflict between the operation of the federal and state laws. At this writing, six states have passed

³¹ This danger is particularly acute in pension-type, self-administered plans where large reserves are accumulated for investment and where payments are deferred for several years. Mistakes may not be uncovered until it is too late to correct them. Isaacson, "Employee Welfare and Pension Plans: Regulation and Protection of Employee Rights," 59 *Col. L.R.* 96-124, 101.

³² Contingency commissions are those which are paid by an insurer to an administering broker if the claims experience of his policy is good. Since the policyholder may be ignorant of this arrangement, and since it is the broker who processes the claims, the (Sen.) Douglas Subcommittee characterized this as "a built-in incentive" to limit the number of successful claims and thereby deny benefits to the participants in whose behalf the insurance had been issued. 59 *Col. L.R.* 96, *supra*, 103.

³³ The group insurance industry as a whole, however, is not permeated by such practices. The Douglas Committee found that most of the industry was operated "in an efficient manner and in accordance with high standards" 59 *Col. L.R.* 96, *supra*, at p. 104. Cf. also the (Sen.) Kennedy Report (S. 2888) pp 10-11:

"While it should be stressed that from all the evidence the great percentage of these plans are honestly administered and that great credit is due to the vast numbers of employers, union officials, administrators, insurance and banking institutions, consultants, actuaries, and others who have been responsible for the impressive record made by this private social-security system, numerous instances of abuses and deficiencies have been uncovered which drain off countless millions of dollars from their intended purposes and in other ways deprive the employee beneficiaries of these plans of what rightfully belongs to them."

special legislation to regulate employee benefit funds: Washington, Wisconsin, California, Massachusetts, Connecticut, and New York. Needless to say, the state laws at this time are neither a uniform³⁴ nor complete answer to the problem.

The current theory is that as long as the Federal Disclosure Act is nothing more than its title implies and the federal government does not actively examine these funds with the view toward regulating them, the states are willing to allow the matter to rest. This is prompted by various considerations including the lack of funds and staff. However, it is inconceivable that at some point the federal government will not make some telling use out of all the statistics in this area which it is now warehousing. If that takes place, of course, there will be renewed interest on the part of the states to regulate in this field.

2. STATE VS. FEDERAL REGULATION.

It is not the function of this discussion to argue the question of federal versus state regulation, especially since the argument becomes involved in the traditional schism in political thinking in this country: states' rights versus federal union.

Arguments for Federal Regulation. That there is much to be criticized in the system of individual state regulation is not to be denied. Chief complaints against it have been:

(1) Lack of uniformity among insurance codes, creating innumerable complications for companies operating in more than one state. For instance, the biggest "headache" of every company is obtaining the approval of new policy forms in all the states in which it operates. Legal departments, actuaries, and underwriters often are completely frustrated by having one state absolutely forbid a certain clause which another state requires.

(2) The additional expense involved in filing financial reports in different states and the cost of maintaining fifty separate insurance departments.

(3) Ill-advised legislation proposed and even passed in various states where legislators are not "professionals" as are the members of the United States Congress, but part-timers often so underpaid for their work that in some cases, the only reason they seek a seat is to be in a position to introduce special-privilege or retaliatory legislation.

(4) The political nature of the appointment or election of insurance commissioners, which too often has produced commissioners who have few qualifications for the job.

(5) Conflict with federal regulations and rulings which, while not aimed

³⁴ The N.A.I.C. Welfare and Pension Funds Blanks Subcommittee succeeded in 1958 in securing agreement among its members on uniform blanks for annual statement and reports to be used by all regulating states.

exclusively at the insurance business, do affect its operations and transactions.

(6) The business is national in scope. The fact that the vast majority of companies operate in more than one state would seem, logically, to call for national regulation.

Arguments for State Regulation. On the other hand, strong arguments have been advanced for the system of state control:

(1) State regulation is better able to give special consideration to local conditions where such consideration is needed.

(2) Federal regulation, which would involve a much larger department than required by any single state, would tend to become cumbersome and involved in red tape.

(3) State regulation is closer to the individual citizen and hence more subject to his observation and control.

(4) Conflicts in state law and practices are steadily being reduced by the activities of the National Association of Insurance Commissioners. The Association has, over the years, demonstrated its ability to accomplish its objectives so that today the complications resulting from company operations in several states have been minimized and are less annoying to the companies.

(5) The effects of ill-advised insurance legislation are localized rather than national in scope.

(6) Federal control would become a great leveling factor in insurance regulation, with the effect of weakening the supervision in those states like New York where it is strong.

Attitude of the Industry. The thinking of the industry itself has not always been on either side of the question of state versus federal control. As previously pointed out, Elizur Wright was a staunch advocate of federal regulation, and most of the cases testing *Paul v. Virginia* were attempts by members of the industry to have insurance declared commerce and hence not subject to state regulation. Many writers in the field, even well into the 1930's, indicated belief in federal as opposed to state control.³⁵ Some have since changed their stand. Moreover, as among company executives throughout history, there has been a difference of opinion as to the desirability of federal regulation of insurance. As state legislation became more bothersome, federal regulation gained more and more support. The greatest drives for federal regulation were made during the years immediately preceding the *Paul v. Virginia* case. The most opposition to these drives seems to have stemmed from the insurance commissioners of the states. The large companies in the East seem to have favored federal control, whereas the small companies in the South and West seem to have favored state control.

³⁵ Cf., for examples, S. S. Huebner, *Life Insurance*, New York, D. Appleton & Co. (now Appleton-Century-Crofts, Inc.), 1915, p. 364 f.; J. B. Maclean, *Life Insurance*, New York, McGraw-Hill Book Co., 1932, p. 393; C. K. Knight, *Advanced Life Insurance*, New York, John Wiley & Sons, Inc., 1926, p. 26; J. H. Magee, *Life Insurance*, Chicago, Business Publications, Inc. (now Richard D. Irwin, Inc.), 1929, p. 604.

Throughout the history of insurance in America, the question of federal supervision of insurance came up time and time again in the form of proposed congressional measures, suggested constitutional amendments, institutional resolutions, and public statements by company executives. Those who opposed the move always won out. At the present time the insurance industry seems to be more closely united in opposition to federal control, especially after studying the New Deal and Fair Deal regulatory practices of two recent administrations.³⁶

3. CHANNELS OF REGULATION.

Four channels of regulation of the insurance business are: judicial, legislative, administrative, and self-regulative.

Judicial Regulation. Much insurance regulation is established by the judicial branch of the government through court decisions. In the American form of government, it is the function of the legislative branch to pass laws, the administrative branch to carry out their provisions, and the judicial branch to interpret legislation when its application to any particular situation is not clear. Consequently, the law of the land originally stemmed from two sources: the legislative bodies and the courts—legislative law and judicial or “case” law.

The insurance industry is subject to both types of “law.” For instance, should the court be called upon to rule regarding the powers or the limitations of the power of the insurance commissioner, that decision, at least until reversed, becomes a part of the body of insurance regulation. The same is true when the court decides on the interpretation of a policy contract, the constitutionality or unconstitutionality of insurance legislation, the liability of a company in borderline cases, and in all the host of decisions which may be handed down in the cases of litigation directly or indirectly affecting the insurance business.

Legislative Regulation. The second branch of the various state governments to have a hand in insurance regulation is the legislative, the legislatures and assemblies of the fifty states, and the Congress of the United States when serving as the legislative body for the District of Columbia. As has been seen in the discussion of the history of insurance regulation, each of the states has a large body of law—usually referred to as the “insurance code”—directly pertaining to the operation, administration, and investments of the various companies domiciled or licensed within the state.

Drafting of legislation in the various states has not been left solely in the

³⁶ For an interesting discussion of the history of attitudes toward federal regulation of insurance, see *A Study in the History of Life Insurance* by R. Carlyle Buley, New York, Appleton-Century-Crofts, Inc., 1953, selections (see Index). President Theodore Roosevelt exerted strong pressure for federal regulation. History shows companies were lined up on “both sides of the fence.” Two United States Senators who were also presidents of life insurance companies were on opposing sides of the issue. Senator Dryden, who was president of Prudential, favored federal control, whereas Senator Bulkeley, president of Aetna, opposed it.

hands of the legislators. As in the case of most legislation, interested individuals and groups offer "proposed" bills which they seek to have sponsored by some legislator who will introduce them for possible passage by the legislature. In general practice today, new legislation or amendments to the insurance code are usually sponsored by the insurance companies themselves, either directly or through associations, and by the various insurance commissioners. It is a widespread practice, when the state insurance commissioner is considering the sponsorship of insurance regulation in the legislature or assembly, for him to hold hearings at which interested parties such as the companies, company associations, and agents, as well as the general public, may express their views or make recommendations.

Legislation is also introduced at times by labor unions or other organized lay groups. One of the most bothersome sources of new legislative proposals is "spite bills" introduced by legislators who have a grudge against insurance resulting from a personal experience or that of a constituent.

As a general rule, state legislative bodies lean heavily on the insurance department both for the sponsorship of any needed legislation and for approval or disapproval of proposed legislation. The attorney general of the state also frequently, if not commonly, assists in the drawing up of proposed laws affecting insurance in the same manner that he does with many other types of law. The National Association of Insurance Commissioners is another source of proposed "model" legislation as was seen, for instance, in the aforementioned Guertin Standard Valuation and Nonforfeiture laws, the Uniform Provisions laws, and many others.

Administrative Regulation. Administrative regulation of the insurance industry is accomplished in the various states by an official or department specifically appointed to see that the provisions of the law are carried out. The official is known as the commissioner, superintendent, or director of insurance and his department, as the department of insurance. (Whatever his official title, he is generally referred to as "commissioner.")

The operations of insurance commissioners are an early American example of what is now known as administrative law. Today this type of law has become identified with a multiplicity of agencies concerned with regulation of economic activity. Prominent examples include the activities of the Interstate Commerce Commission, the National Labor Relations Board, state utilities commissions, the Securities and Exchange Commission, and many others. Administrative law evolved out of the necessity for both flexibility and technical understanding inherently impossible in either the normal legislative or judicial processes.

The essence of administrative law has been the granting by the legislative branch of a field or scope of authority to an administrative agency which both makes and enforces rules within the limits of the initial grant and subject to judicial review. For example, as noted below, insurance commissioners are given the power to regulate the valuation of insurance companies' assets.

This power is effected by the establishment of particular rules of valuation which he can change from time to time as economic conditions and knowledge of investment principles change.

Discretion in enforcement is also available when power to revoke a company's license is given in such language as "whenever in the judgment of the Superintendent of Insurance it will best promote the interests of the people of this state. . . ." The insurance commissioners in some states have the power to levy fines after a formal hearing of the charges. Obviously, in making decisions, the commissioner is setting up rules of conduct; i.e., creating administrative law. Of course, such rules must always lie within the general scope of powers granted by the legislature to the administrator, and the courts stand guard to see that these are not exceeded and that neither willfulness nor arbitrariness appears in their application.³⁷

An insurance commissioner combines the functions of an official clerk, judge, legislator, and often prosecutor, judge, and jury. Partly judicial, partly legislative, and partly administrative, he is not confined within any of these areas.

The powers of a commissioner are broad and discretionary. By direct or indirect means he can bring about compliance with almost any rule he promulgates. In fact, the powers of a state commissioner may even be extra-territorial. For instance, no company has successfully challenged the right of the New York department to require "substantial compliance" with New York law in all other states in which a company operates as a condition of licensing in New York. Thus, for one example, a company licensed in New York must observe the maximum commission allowances set by New York in every state in which it operates no matter in which state the company is domiciled.

Self-Regulation. The final channel of regulation of the insurance business is self-regulation; i.e., those restraints imposed on the business from within the industry both through individual company conscience and through group pressure and associations. Self-regulation was the first type of insurance regulation in America and is the predominant type in Great Britain.

There is a sense of trusteeship in the insurance business that acts as what might be called the "individual company conscience." The cynic will say that good behavior is a result of necessity, that the business is under such intense public scrutiny in all phases of its operation that it is "the better part of valor" to act in the public interest. However, the source of such operating philosophy matters little to the fact that it does exist.

³⁷ Some judicial authorities are seriously concerned by the great advances in administrative law. Judge Brennan in a court opinion had this to say: "Concern with the problem of merger of the powers of prosecutor and judge in the same agency springs from the fear that the agency official adjudicating upon private rights cannot wholly free himself from the influences toward partiality inherent in his identification with the prosecuting aspects of the case . . . in a sense the combination of functions violate the ancient tenet of Anglo-American justice that 'No man shall be a judge in his own cause.'" (In re Larsen, 86A2D 430, 436.)

Through trade associations, business conscience becomes even more important as a foundation for self-regulation. All the associations discussed in Chapter 25 serve to regulate the business, both by their very existence and through "codes of ethics" and similar statements and agreements adopted by them. For instance, in 1950 the National Association of Insurance Commissioners took action to approve and adopt a "Statement of Principles for Personal Accident & Health Insurance" drawn up by an industry committee. It includes principles for the construction of policy forms; principles applying to policy provisions and their uses, particularly exclusions, qualifying and waiting periods, and disability definitions; and principles applying to advertising and soliciting materials. As another example, in 1954, prior to the release of the FTC complaints, members of both of the health insurance associations existing at that time adopted voluntary codes of advertising standards for individual health policies and required members to agree to the codes as a condition of membership. The "Code of Ethical Practices with Respect to the Insuring of the Benefits of Union or Union-Management Welfare and Pension Funds" was adopted by the N.A.I.C. in 1957 and is voluntarily followed by many companies.

As further self-regulation, the agents' associations such as the National Association of Life Underwriters, the American Society of Chartered Life Underwriters, and the International Association of Health Underwriters all have codes of ethics for their members. Unfortunately, however, as in other business and professional groups, some members of these associations fail to take the codes seriously enough.

4. WHAT IS REGULATED?

A list of duties or powers of an insurance commissioner actually constitutes a list of those aspects of the business which are subject to state regulation. At least four of these regulatory areas deserve specific treatment. They are the formation of new companies, financial solvency, product regulation, and field practices of agents and brokers.

Organization of New Companies. It is the function of the insurance department or commissioner to supervise and act upon the formation of new companies, making certain that these companies conform to the requirements established by the insurance code and interpreting that code whenever such interpretation is needed.

Since the New York Code has been widely copied and used as the model in many other states, it will serve to illustrate the details of regulation dealing with the formation of new companies.

The New York law requires those contemplating the formation of a new life insurance company to draw up a charter giving among other data the name of the company, the location, the kinds of business it plans to write (life, life and annuities, annuities, life and health, or the like); the power of the company officers and how these powers are to be exercised; methods of

internal government, and, if a stock company, details of stock arrangement. Next, the founders must advertise their intention to incorporate as an insurance company and file a certificate of intention and a copy of the charter.

After the charter is approved, and the certificate recorded, a stock company may sell stock or a mutual company may solicit applications for insurance, but neither can yet issue policies. Organization under the New York law is complete in the case of mutuals, when the premiums on a necessary minimum of insurance have been paid, when the necessary statutory surplus has been cleared with the superintendent of insurance, and when the directors who are elected have authorized the issue of the policies. A stock company organization is complete and policies can be issued when the total amount of capital and surplus has been paid in, when the statutory deposits have been placed with the superintendent of insurance, and when the directors have been elected and have authorized the issuance of the stock.³⁸

Under New York law, since it is easier to organize a stock company than a mutual, companies sometimes are formed as stock corporations and then later are mutualized. When Hyde formed the Equitable Assurance Society of New York, he referred to it as a mutual; but he had to organize it as a stock company.³⁹

A difference exists between the *organization* of a company and the *licensing* of a company, and regulation covers both. The control of the insurance business by the state is exercised chiefly through its licensing power. The primary purpose of the requirements of licensing today is not revenue-raising, as was probably the original intention, but regulation. A license is a document stating that the company involved has complied with the laws of the state and is authorized to engage in the kind of business or businesses specified. A license might well be called a certificate of authority. Although life insurance underwriting by an individual rather than a corporation is not everywhere prohibited, little if any such business is written in the United States today.⁴⁰

A license to write life or health insurance may be issued to a domestic company, a foreign company, or an alien company. The state has the right to set up requirements for the issuance of a license to foreign or alien companies which are more stringent than those required of domestic companies. For instance, in New York and Massachusetts domestic companies are required to obtain licenses only once, and need not renew them. Moreover, the grounds for the revocation of a domestic company's license are usually more limited in comparison with those applied to a foreign or alien company.

While such discrimination might appear to be local favoritism, it must

³⁸ Cf. Chapter 24 for minimum financial requirements for the organization of stock and mutual companies under New York law.

³⁹ The company has long since been mutualized.

⁴⁰ Frankly, no statistical compilations show any, and the authors never heard of any; however, the authors have also found that it is unwise to make categorical statements to college students. Someone always comes up with an exception.

be remembered that the assets of a domestic company are domiciled within the borders of the state and subject to the control of the commissioner of insurance of that state through court procedure. However, the insurance commissioner in any given state has no power to seize assets domiciled in another state, and often he cannot even sue in the other state for that purpose except when acting as a liquidator or receiver.⁴¹

Financial Solvency. A second important area of insurance regulation pertains to the financial condition of the company. Regulation in this area breaks down into four categories: (1) the power to compute reserve liabilities, (2) the power to value assets, (3) the power to approve investments, dividends, and expenses, and (4) the power to require a deposit of security. All but the last of these require discussion.

Computation of Reserve Liability. The Guertin Standard Valuation and Nonforfeiture legislation, which has become virtually standard in all states, requires that life insurance company reserves must be those calculated from the 1941 Commissioners Standard Ordinary Mortality Table at 3½ per cent (the use of the 1958 table is optional) or a mortality table and interest rate giving, *in the aggregate*, higher reserves. The law also prescribes the use of the Commissioners Reserve Valuation Method. Health insurance carriers must set up unearned premium reserves, loss reserves, and in the case of non-cancellable contracts, an active life disability reserve.

The Evaluation of Assets Any company may be made to appear solvent if its securities are evaluated high enough. Consequently, state commissioners are empowered to determine the method of evaluating securities of an insurance company for the purposes of determining whether or not that company is in a sound condition. Formulas for the evaluation of securities are both complicated and lengthy. They are designed to make certain that life insurance companies do not overvalue assets in reporting them. As a result, a more than ordinary amount of reliance may be placed in the financial statements of insurance companies in determining their financial strength. Without formulas for the evaluation of assets, requirements for reserves would be meaningless.

Investment Regulation. The types of investments in which an insurance company may place its funds are restricted by statute and regulation. For example, companies doing business in New York are restricted to substantially the following types of investments:

- (1) obligations of the federal, state, or municipal governments in the United States or its possessions, which are not in default as to principal or interest;
- (2) obligations of solvent United States corporations with a prescribed earnings record or secured by specific property;

⁴¹ Since the SEUA decision declaring insurance interstate commerce, the courts have consistently held that a differential imposed on a foreign insurer as contrasted to a domestic insurer is not in restraint of trade, as might appear.

(3) mortgage loans secured by first lien on real property; bonds or notes insured or guaranteed by FHA or VA; bonds, notes, mortgages, etc., issued by slum clearance or development corporations;

(4) stock and debt obligations of housing and real estate companies;

(5) equipment trust obligations or certificates;

(6) obligations issued by receivers administering the assets of institutions under judicial supervision;

(7) certain bank and bankers acceptances & other bills of exchange;

(8) Federal Home Loan bank stocks;

(9) obligations issued or guaranteed by the International Bank for Reconstruction and Development;

(10) shares of savings and loan associations;

(11) investment in housing projects;

(12) investment in company-occupied real estate; limited investment in income-producing real estate;

(13) limited investment in preferred and common stocks meeting certain qualifications, including an earnings test;⁴²

(14) limited investment in Canadian and certain other foreign securities of types and qualities that would qualify as domestic investments for life insurance company holdings;

(15) additional investments, not otherwise qualifying, to the extent of 2 per cent of admitted assets, but without altering any amount limitations elsewhere imposed on individual investments or classes of investments.

Interesting variations are found in laws of other states. For example, the Illinois law allows companies to invest 5 per cent of admitted assets without restriction. Texas requires that life insurance companies licensed there must invest in Texas real estate and securities at least 75 per cent of their assets which offset the legal reserve required on policies written on the lives of Texans.

In general, laws regulating life insurance company investments are designed to restrict the investments, not only into specified classes of securities, but also to the proportion of funds that may be invested in any single issue in order to assure diversification. Even with the numerous restrictions on the investments of life insurance company funds, carriers have wide latitude for use of discretion in how these funds will be invested among the permissible classes. For example, a study of the issues of *The*

⁴² Investments in preferred stocks were first permitted in New York in 1928, and investment in common stocks was authorized in 1951. The amount which a company operating in New York may invest in common stocks is limited to 5 per cent of admitted assets or one-half of its policyholders' surplus, whichever is less. There are other restrictions on the investment in particular issues. Preferred stocks constitute about 1.4 per cent of all assets of life insurance companies, and common stocks constitute about another 2.6 per cent. Investments in real estate, which represented only 1.5 per cent of total assets in 1946, have more than quadrupled since that time, following amendment of state laws permitting such investment. Total real estate holdings now represent 3.2 per cent of total assets.

Life Insurance Fact Book will reveal major changes in the distribution of investments, with a wide shift from government bonds to industrial bonds and to mortgage loans being the most in evidence during the last decade.

Regulation of Expenses. Only two states have laws limiting the amount that life insurance companies may spend on expenses. However, inasmuch as one of the states is New York,⁴³ whose regulation as previously mentioned has an extraterritorial effect, the limitations imposed have widespread application.⁴⁴

The New York expense limitation requirements grew out of the findings of the Armstrong investigation which revealed extravagance in amounts spent, especially for the acquisition of new business. The limitation is placed on a specific list of items involving first-year expenses incurred in issuing a policy, the total of which must not exceed the first-year expense allowance. These items include: first-year commissions; additional compensation paid in obtaining new business but not included in commissions nor forming a part of supervision costs; advances to agents; compensation and expenses of home office personnel who spend more than one-third of their time in the field; a percentage of advertising cost; and the amount by which the total of six items exceed a given amount (based on specified percentages) of the renewal premiums on life insurance and annuities plus flat amounts for each \$1,000 of all insurance in force and each \$1,000 of insurance in force not paid up. These six items are renewal commissions, service or collection fees, special compensation, cost of agency supervision, agents' pension plans, and certain specific branch office and agency expenses.⁴⁵

Rate Regulation. Life and health insurance rates are not regulated in the same sense that rates are controlled in certain fire and casualty lines. Reserve requirements in life insurance assures the adequacy of rates, whereas competition assures that the rates will be reasonable. Unfair rate discrimination among buyers of the same policy is prohibited. In the health insurance field, rates and loss ratios sometimes are checked indirectly before the department approves policy forms. The majority of states require that health insurance rates and occupational classifications shall be filed with the commissioner. Some few states require that rates as well as policies be approved by the commissioner. A number of states provide that the commissioner's approval shall be withdrawn if the benefits payable are unreasonable in

⁴³ The other state is Wisconsin. Its limitations relate to both first-year expenses and total expenses. A maximum allowance for expenses is calculated for each policy according to duration as specified by law. The totals of such allowances for first year only and for total business are compared with corresponding expenses of the calendar year excluding certain items, mainly investment expenses, taxes, licenses, and fees. This Wisconsin law also is extraterritorial in effect.

⁴⁴ Although companies licensed in New York are, by number, only about 10 per cent of all companies in the United States, they represent about 85 per cent of all assets held by United States life insurance companies.

⁴⁵ Smaller companies (less than \$500,000,000 in force) are allowed to increase their expense limits over those for the larger company.

relation to the premium charged, but no exact standards of "reasonableness" are set. In another small group of states, the filing of a policy form for approval must be accompanied by an estimate of loss ratios expected under the coverage. Since about 1945 a majority of states have required the filing of an annual statement of loss ratios by policy forms at the suggestion of the National Association of Insurance Commissioners, which in that year expressed the desirability of health insurance loss ratio information. No action, however, has ever been taken on the statistics gathered.

Product Regulation. In nearly all states, policy forms in both life and health insurance must be filed with the insurance commissioner. In some states, approval is required before the policy can be issued. In others, if not disapproved within a certain period of time, the policy may be issued. Generally speaking, the commissioner may disapprove if a life or health form contains provisions that are unjust, unfair, inequitable, misleading, deceptive, or encourage misrepresentation. His authority is highly discretionary.

In addition, policy forms in both the life and health insurance field must contain a number of "standard" provisions.⁴⁶ Standard provisions have advantages to both company and policyholder by making for some degree of uniformity among insurance policies. They eliminate the necessity of bargaining for each individual policy and make mass production possible. They facilitate the gathering of statistics to measure costs accurately. They assure fair and equal treatment to policyholders, and lead to a better understanding of policies and their meaning.⁴⁷

Group Regulation. In general, much that has been detailed above in regard to rate regulation and policy forms relates to individual policies. In most states, group insurance is regulated by a special set of laws. Laws relating to group insurance usually include: the definition of a group, the minimum size of a group, and the percentage of participation required in contributory plans. Approximately forty states have established special group policy form requirements. They cover such things as the definition of a contract, representations, issuance of certificates to individuals covered, new admissions, remittance of premiums, time limit on notice of claim, proof of loss, time limit on filing proof of loss, payment of claims, physical examination and autopsy, and time limit on legal actions. Provisions relating to all these issues, however, are not found in every state group insurance law.

In group life insurance, a few states set the minimum first-year premium. After the first year, premiums may be adjusted to the loss experience of the

⁴⁶ These standard provisions are discussed in Chapters 8 (for life insurance policies) and 11 (for health policies).

⁴⁷ Dr. J. E. Hedges, of Indiana University, writing in *Law and Contemporary Problems*, XV, p. 358, says of the advantages of eliminating the doubt in the minds of buyers of the meaning of insurance contracts: ". . . much of the mystery with which insurance seems to be shrouded in the public mind tends to disappear. With the disappearance of mystery, there tends to come the confidence so necessary if insurance is to provide the peace of mind which is one of its greatest services."

particular group. Minimum first-year premiums are not required in group health insurance, although in practice filed rate schedules are usually followed the first year, the rate being adjusted thereafter by experience of the group.

In the field of group health insurance special legislative and regulatory consideration is also given to blanket and franchise forms.

Regulation of Field Practices. As previously mentioned, agents and brokers must be licensed by the state.⁴⁸ Qualifications for obtaining a license as an agent or broker vary widely from state to state. Applicants may or may not be subject to any particular qualifications or examination. The agent must, of course, be authorized by the company. The very term "agent" indicates that he has been designated by his principal (the company) to act as its representative in the transactions specified in his contract. In a growing number of states, written examinations are required. In other states, the law assumes that in view of the fact that the agent has extremely broad power to commit his principal, the company can be depended upon to use care in selection of agents.⁴⁹ However, there is a definite tendency to tighten agents' licensing and qualification requirements, as a result of the exertions of state agents' associations.

Agents' licenses may be refused or revoked by the insurance commissioner, but not without "cause," such as dishonesty, twisting, rebating, fraud, untrustworthiness, etc.⁵⁰ Dishonesty or fraud in the past is usually grounds for rejection of an application for a license. Some few states appear to regard incompetence or ignorance as grounds for rejection of a license. If serious qualification laws ever are adopted or if licenses ever are to mean more to the public than a source of state revenue, these two elements (incompetence and ignorance) will have to be given more recognition and weight than it seems are being given to them today.

Penalties are usually provided in state insurance codes for doing business

⁴⁸ Some states make a distinction between brokers and agents for purposes of licensing. In some other states, the same license is issued to brokers as to agents. In still others, there may be no provision for a broker's license in life insurance.

⁴⁹ Advocates of a qualification law requiring completion of an approved course of study claim that the result is better training than that required to pass state examinations, which are usually weak by academic standards and often test only rote memory. Advocates of examination laws charge that under a qualification law, there is no outside check on whether or not the agent actually completed the course and, if he did, whether he "passed." One state with a qualification law has sought to meet the problem by requiring that the new agent complete a comprehensive examination (or a series of examinations) over the course studied, that the results of the examination show reasonable comprehension of the subject matter of the study course, that the examination be in the agent's own handwriting, and that examination papers be held by the general agency, branch office, or home office for a period of two years, subject to a spot check by the insurance department. Agents' associations are usually the strongest advocates of the examination system (and of "tight" licensing laws in general). Companies and managers often complain that the agents' idea of a license examination is one no one could pass until he had been in the business ten years.

⁵⁰ There is always appeal from the rulings of a commissioner to the courts.

as an agent in the state without a license. In general, these penalties are similar to those applied to a company that operates in a state without a license. They usually are of two types: criminal and civil. Criminal penalties may run as high as \$2,000 fines and jail sentences up to one year. Assessment of these penalties can be made only after due trial as provided for all criminal offenses. Such trials are infrequent. More deterring than criminal penalties are the civil penalties, which may include the refusal of the court to allow the agent to recover against his company for nonpayment of commissions.

In most states, licenses must be renewed annually, such renewal usually being made on application and payment of the proper fee. Some states issue perpetual licenses, but an annual fee is still required by most states. Also, some few states license insurance counselors, auditors, or analysts. In most states, however, such "counselors" are usually self-appointed.

High among causes considered sufficient for license revocation are *rebating*, *misrepresentation*, and *twisting*.

Rebating is the practice of returning part of the premium or giving a valuable consideration in return for the application for the policy. Rebating generally takes the form of a refund of part of the commissions on the business. Regulation of rebating is aimed at maintaining a fair plane of competition among agents, the philosophy being not *free* competition, but *fair* competition. The prohibition against rebating also is designed to protect the career agent from the avocational agent. The career agent, i.e., the agent who earns his entire livelihood from the life insurance business and who contemplates remaining in that business throughout his career, is to be encouraged in favor of the man who "picks up a little money on the side," the avocational agent. The latter, of course, not depending for his living on his life insurance sales, may be more prone to return part of the premium to the applicant as consideration for buying insurance.

Rebating is not clearly defined by law. State laws usually provide that a rebate may consist not only of part of a premium, but also any inducement, favor, or advantage not specified in the policy. In some jurisdictions, it is illegal for an employer to accept a commission for a policy issued to an employee, or for an employee to accept one for insurance on an employer. Sometimes, attorneys are prohibited from accepting fees for inducing a client to take insurance. Rebating may even extend to an agreement to render certain tangible services, say, for example, to do a specified amount of work for the applicant in return for his application. The acceptance of interest-bearing notes instead of cash, however, has been held not to constitute a rebate.⁵¹ The acceptance of noninterest-bearing notes would be open to question as well as would the waiving of interest charges on interest-bearing notes, a practice sometimes used especially in connection with student business. As

⁵¹ *Diehl v. American Life Insurance Company*, 204 Iowa 706, 213 N.W. 753 (1927).

a further precaution, agents are expected to write a fair amount of business for people other than themselves and their immediate family so that commission payments do not indirectly become a rebate.

In many states, rebating is a legal offense (usually a misdemeanor) for the agent, and in others, it is an offense for both the agent and the person receiving the rebate. Few rebating cases actually appear in court. A rebating case is difficult to prove, especially since under the law of some states both parties, the buyer and the seller, are guilty. Neither will desire to testify against the other and hence incriminate himself.

Misrepresentation involves the making of any unfair, misleading, or incomplete comparison of two policies, or any misleading statement about the financial condition or reputation of another company or of any of the relationships between the insured and the company.

Twisting refers in general to misrepresentation in order to induce a policyholder to drop a contract he already has and to replace it with a new one. The practice generally relates to dropping a policy in one company in favor of taking a policy in a different one, although twisting might also consist of inducing a policyholder to drop a policy in the agent's own company in order to take another one in that same company.⁵² Twisting is difficult to define; and inasmuch as there are, on occasion, valid reasons for having a policyholder drop one policy and replace it with another, the definition of twisting must include failure to disclose all the facts. Regulations against twisting are fostered and encouraged by the companies inasmuch as twisting increases the incidence of lapsation and the ratio of acquisition costs to total expenses.

Unfair discrimination is another prohibition in most states, although it is not an act usually committed by an agent. The word "unfair" must be stressed, for in a sense discrimination in the selection of risks is the very essence of insurance. "Unfair" discrimination usually is interpreted as treating risks within the same class differently.

5. TAXATION OF LIFE INSURANCE COMPANIES.

The life insurance business is subject to both federal and state taxation. In fact, taxes, licenses, and fees take about \$4.00 out of each \$100 of income received by United States life insurance companies. The total paid in taxes by the companies in 1959, exclusive of real estate taxes, was close to \$900 million. This represents more than 40 per cent in excess of 1958 tax payments, the increase being largely due to higher federal income taxes under new legislation, as described below.

The Federal Income Tax. Because of the special nature of life insurance operations, the federal income tax formulas applied to that branch of

⁵² The fact that first-year commissions on new policies exceed the renewal commissions on an old one might tempt an unscrupulous agent to twist his own policies to the disadvantage of his client.

the business continually have failed to meet the revenue expectations of the Treasury Department. They have also failed to satisfy the life insurance industry's desire for an equitable tax formula. Frequent revisions of the applicable tax law have resulted. These revisions fall into several broad periods.

Prior to 1921, life insurance companies were taxed like commercial corporations. All earnings from whatever source were considered gross income. All expenditures, including charges for reserves, were deductible from gross income. The corporate rate was applied to the net, taxable income so determined.

The 1921 law set up special tax provisions for life insurance companies. Under these provisions, premium income was treated the same as capital deposits which the insurance company invested for the benefit of policyholders. The only new income accruing to the life insurance company was considered to be investment income. Underwriting income was ignored. Net taxable income consisted of gross investment income, minus investment expenses, minus interest necessary to maintain legal reserves. The last deduction recognized the fact that life insurance companies are contractually obligated to credit a given rate of interest on policyholder reserves, whether net investment income is sufficient for this purpose or not. Gains from sales or redemptions of securities, interest from tax-exempt securities, and dividends received on stocks of corporations subject to federal income taxes were not considered as part of investment income.

From 1921 to 1932 the interest required for maintaining reserves was set at 4 per cent. This rate was applied to each company's mean reserves for the year in order to determine the allowable deduction. In 1932 the rate was lowered to 3.75 per cent and remained at this level until 1942. During the latter part of this period, companies, because of declining interest earnings, began reducing interest assumptions on new policies with the result that the government failed to get what it considered to be a reasonable tax income; so the formula was changed in 1942.

From 1942 to 1948 the interest required for maintaining reserves was computed by applying an industry-wide ratio to each company's investment income rather than to the mean of its reserves. This ratio was computed on an industry-wide basis giving a weight of 35 per cent to the actual rate assumed by each company on its reserves and 65 per cent to an assumed rate of 3.25 per cent. The amount obtained by applying this weighted rate to legal reserves constituted the major portion of the ratio's numerator. The denominator consisted of net investment income available to the industry to meet policyholder commitments included in the numerator. This ratio was known as the secretary's ratio, and when subtracted from 100 per cent, measured that portion of the investment income of each company subject to federal income taxation. For example, the ratio in 1942 was 93 per cent; so 7 per cent of each company's investment income was subject to taxes at regular corporate rates. The application of this formula provided additional tax in-

come to the government and, at the time, seemed satisfactory. But a continued decline in interest earnings and an increase in deductions resulting from reserve revaluations produced a situation in 1947 in which the secretary's ratio exceeded 100 per cent, so that the formula produced virtually no taxable income.

In 1950 a new averaging formula was established, using the 1942 system, except that it discarded the 35 per cent to 65 per cent weighting system in favor of the actual average valuation rate of interest for all companies. To assure the government that the ratio obtained would be less than 100 per cent, companies whose assumptions would have produced a negative amount of taxable income were eliminated from the calculation. This formula was applied only during the taxable years 1949 and 1950.

In 1951 a temporary bill was enacted that provided for a tax of 6.5 per cent of the net investment income of life insurance companies less certain deductions. These deductions were provided for health insurance reserves and for companies not earning sufficient interest to meet their reserve requirements. This law was extended one year at a time through 1954. This change in approach was made because it was simple in its conception and application. It assumed that since the amount of net investment income needed to meet interest requirements on reserves would remain relatively constant, no specific deduction need be allowed. This expectation did not materialize.

In 1955 another temporary measure was passed that provided for a tax at the corporate rate of 52 per cent on the net investment income of life insurance companies after allowing for a deduction for the interest required to meet reserve liabilities. Under the formula, the amount each company was permitted to deduct to meet interest requirements on reserve was 87.5 per cent of the first \$1 million of net investment income and 85 per cent of the balance. These figures were chosen on the theory that in the long run approximately 85 per cent of net investment income is needed to meet interest requirements on policyholder reserves. The 87.5 per cent deduction was designed to aid small companies.

This law gave special tax consideration to those companies failing to earn sufficient investment income to meet their individual reserve requirements. It also taxed income received on cancellable health insurance differently than income received on life insurance operations. This was the first time such a distinction had been made. The 1955 formula was extended through the 1957 taxable year, and produced a tax of about 7.8 per cent of net investment income for these years.

All the tax formulas applied after the abandonment of the 1942 approach were on a stop-gap basis. In any year in which new tax legislation had not been enacted or the current formula extended, the 1942 formula would have reapplied.

In 1959 a new tax law was enacted. Its provisions were made retroactive to 1958. This law replaces the 1942 legislation as the permanent method

of taxing life insurance companies. Several features of the new law deserve special mention. *First*, the taxation of stock life insurance companies is on a somewhat different basis than the taxation of mutual companies. *Second*, the investment income approach to the taxation of life insurance companies has been abandoned. It has been replaced with a total income approach similar to that employed prior to 1921. *Third*, interest required to maintain policyholder reserves is determined on the basis of individual company experience. Formerly, a uniform rate was used by all companies. *Fourth*, interest earnings on reserves held for qualified employee benefit plans are given the same tax treatment in the hands of a life insurance company as that received by a trustee. *Fifth*, more liberal tax provisions are applied to both small and new companies than embodied in any previous act.

The tax rates applying to corporations generally also apply to life insurance companies. Life insurance company taxable income is defined as the sum of (1) taxable investment income⁵³ plus (2) 50 per cent of the amount by which gain from operations exceeds taxable income⁵⁴ plus (3) the amount subtracted from the policyholder's surplus account for the taxable year.⁵⁵ A separate tax of 25 per cent is imposed on capital gains to conform to provisions applicable to other corporations.

Gain from operations will be smaller than taxable investment income if there are underwriting losses. Gain from operations will be greater than taxable investment income if there are underwriting gains. If there are underwriting losses, the full amount of such losses is allowed as a credit against

⁵³ Taxable investment income is the net investment income less a deduction for the interest required to maintain reserves, which consists of three elements

(1) A deduction for earnings on reserves at the lower of a company's earnings rate and the five-year average of such rate, as applied to reserves revalued at such rate by an approximate formula known as the "ten for 1" rule.

(2) Interest actually paid on funds left on deposit and on indebtedness.

(3) A special deduction for interest on reserves for qualified pension plans

A further deduction is then allowed of a proportion of tax-free interest, partially tax-exempt interest, and the dividends-received credit.

⁵⁴ Taxable income is designated as net investment income plus premium income, less deductions for required interest, claims, expenses, increases in reserves, and the "life insurance company's share" of wholly and partially tax-exempt interest. There is also an allowance for nonparticipating premiums and for group premiums. This resulting figure can be considered as underwriting income for stock companies only, since the additional deduction for policyholders' dividends generally results in eliminating the tax under this phase for mutual companies.

⁵⁵ Under this phase stock companies pay tax on the underwriting income which has not been previously taxed. This is accomplished by considering new surplus as being divided into two accounts:

(1) Shareholder's surplus account

(2) Policyholder's surplus account

The shareholder's account receives all income which has been previously taxed plus capital gains (after taxes). Cash dividends may be paid to shareholders from this account without incurring additional taxes. The policyholder's account receives all income which is not taxed under phases 1 and 2, and all cash dividends paid from this account are first subjected to a 52 per cent tax.

investment income. The tax base in this latter case would be gain from operations plus the amount subtracted from the policyholder's account.

Only 50 per cent of apparent underwriting gain is currently taxed on the theory that true underwriting gain cannot be determined for a twelve-month period. The long-range nature of most life insurance contracts accounts for this view. In order to prevent that portion of underwriting gain not currently taxed from escaping tax liability altogether, the concept of the policyholder's surplus account was introduced.

Additions to the policyholder's surplus account include (1) underwriting income which has not been currently taxed, (2) the deduction allowed for certain nonparticipating contracts, and (3) the deduction of 2 per cent of the premiums for the taxable year attributable to group life insurance contracts and group health insurance contracts. The latter two amounts are deducted in determining gain or loss from operations. These deductions, like the 50 per cent deductions of underwriting gains, are allowed because such amounts may be necessary for the protection of policyholders. If distributions are made to stockholders from the policyholder's surplus account, it is evident that management has decided that amounts previously set aside are no longer needed for the protection of the policyholder. Regular corporate rates apply to distributions when they are made.

In addition to federal income taxes, life insurance companies are subject to all other federal taxes imposed on business generally, such as Social Security taxes, transfer taxes on securities, and the like.

State Taxes. The major tax imposed on life insurance companies by state governments is a tax on premiums, usually about 2 per cent. Originally, the tax was a tariff on out-of-state companies designed to protect home companies. Later it became a retaliatory measure against taxes imposed by other states on out-of-state companies. Today some states still make a differential between the rate charged home companies and that charged foreign and alien companies. Some states do not impose a premium tax on domestic companies. A number of states impose a tax on annuity premiums.⁵⁶

The premium tax has developed into a revenue measure and is an important source of state funds in many states. It has been estimated that no more than 4 per cent of the total premium tax collected by states is used for the regulation and supervision of the business.⁵⁷

The premium tax levied against life insurance companies is subject to question on the basis of tax theory. The question is controversial, however, because there are many different theories regarding taxation, and also taxa-

⁵⁶ In addition to the states, some cities levy a premium tax.

⁵⁷ As a matter of fact, as of December 31, 1958, the last year for which figures are available, the states collected more than \$520,000,000 in premium and franchise taxes and fees. Of this total amount 3.91 per cent was spent for insurance department expenses, ranging from less than 1 per cent by Mississippi to more than 7 per cent by Massachusetts, Texas, and New York and more than 8 per cent by New Mexico.

tion itself is potentially not only a revenue-raising medium but also a tool for social adjustment. Some economists hold to the theory that taxes should be levied on the ability to pay and that they be levied directly; i.e., recognizable as a tax. If these are the tests of a "good" tax, then premium taxes applied against life insurance are not theoretically acceptable.

If, on the other hand, this theory is cast aside and the question is looked at historically, it becomes clear that throughout history some taxes, at least, have been levied with two thoughts in mind: the amount of revenue they will raise and the ease with which they may be collected without objection by voters. If these tests are used to determine what is a fair tax, then the life insurance business is properly taxed.

In addition to the premium tax, insurance companies are subject to various miscellaneous state taxes and fees such as license fees, filing fees for annual statements and other required documents, fees for certification of valuation, cost of triennial insurance department examinations, general property taxes, and the cost of required public advertising of annual statements.

At the present time state premium taxes exceed \$520,000,000 annually, more than twice as high as a decade ago. In addition, the companies are required to pay approximately \$45,000,000 in miscellaneous taxes, licenses, and fees, nearly all of them to state and local governments. These taxes alone absorb about \$2.00 out of every \$100 collected in premiums. Federal taxes absorb another \$3.00. This tax burden has been termed as "a capital levy on the process of saving one's own money for one's own family" and is reported to have "no counterpart . . . in any other field of taxation."⁵⁸

6. SUMMARY.

Because of its effect on the public, the large scale of its operations, and the technical nature of the business, life and health insurance are subject to a high degree of governmental regulation. Such regulation, aside from the regulation involved in restrictions in corporate charters, began with the establishment of an insurance department in Massachusetts in 1858. An assumption of the authority for regulation by the states as opposed to the federal government was implicit from the beginnings of the business until 1869, when the Supreme Court of the United States rendered a definite decision that insurance was not commerce and hence not subject to federal regulation.

State regulation was greatly tightened after the Armstrong investigation in New York and the passage in that state in 1906 of a "tight" insurance code. Other states following the lead of New York subsequently strengthened their codes. Then, in mid-1944, the Supreme Court reversed its deci-

⁵⁸ Testimony of R. L. Hogg and Claris Adams representing company interests before the House Ways and Means Committee in December, 1954. They also declared, "Life insurance savings are taxed much more heavily here than they are either in Canada or Great Britain."

sion of seventy-five years' standing and, in two cases decided the same day, declared insurance interstate commerce and hence subject to federal regulation.

The decision immediately threw state and federal law into conflict. These conflicts were resolved when Congress passed the McCarran Act, Public Law 15, declaring a moratorium on the application of the federal anti-trust laws to permit states to bring their laws into line with the federal requirements and declaring (1) that no practice required by a state should be held in violation of federal laws and (2) that it was the intent of Congress to leave the regulation of the insurance business to the states, with the federal government entering the regulatory picture only where state regulation might be inadequate. To date, the federal government has passed no specific laws superseding state regulatory law; but some observers feel that federal regulation is coming by an evolutionary rather than a revolutionary process. They point to moves to regulate insurance practices by such federal agencies as the Federal Trade Commission. The question of federal versus state regulation of the business can be argued endlessly and eventually becomes mixed up in the traditional political schism in the United States: states' rights versus federal union.

Four channels of regulation are in evidence in the insurance business: judicial, administrative, legislative, and self-regulative. In the field of administrative regulation, power is chiefly in the hands of state insurance commissioners. These powers are broad and discretionary and cover almost every phase of operation, with possible exception, in the life and health insurance of rate regulation. There are neither rate regulations nor standard policies in either the life or health insurance field; they are found in the fire-casualty fields.

The life and health insurance business are subject to federal and state taxation. The federal income taxation of life insurance is difficult because of the nature of the special policy reserves peculiar to the business. In effect, the company acts as a depository of funds, which it invests in the interests of policyholders, and which it returns to them as required under the terms of the policy. Therefore, it becomes difficult to determine what actually is taxable income. The result is that ever since the passage of the income tax amendment to the Constitution, the formula for imposing federal income tax liability on the life insurance companies has been subject to constant revision. A permanent income tax law was adopted in 1959. It was made retroactive to 1958 and uses the total income approach.

The major tax imposed by states is a tax on premiums, usually around 2 per cent. Such a tax is held by many to be unfair because it is a tax on savings, but the ease with which it can be collected is in its favor as a revenue producer. Few policyholders understand that such a tax merely increases the premium they must pay, and therefore few of them object as voters.

Government regulation of the business, while at times onerous, irritating,

and obviously containing inequities, has resulted in a high degree of public confidence in the insurance business. Furthermore, it has protected the ethical company against ruinous competition from the promotional company. Weighed in an over-all balance, regulation seems to have been of more benefit to the business than it has been a detriment, and there is little question but that it has had much to do with the stability and security for which the business is noted in this country

QUESTIONS FOR CLASS DISCUSSION

1. The life insurance business is one of the most closely regulated of all businesses. Is this unfair discrimination against the life insurance business?
2. Do you agree with Elizur Wright that the decision in the *Paul v. Virginia* case was "a blow to the sound regulation of the business?"
3. If you had been a member of the Supreme Court, would you have voted to reverse the *Paul v. Virginia* decision in the SEUA case?
4. How effective are state antitrust laws?
5. Are life insurance rates regulated? Are health insurance rates regulated? Do you think these rates should be regulated?
6. Do you agree or disagree with the following statement? "I submit that it is the function of the judge only to interpret the law as it is, uninfluenced by his own idea of what it should be, or by his desires to render his own ideas of alleged justice. It is not for the courts to rewrite the law or subvert its meaning. The legislative branch enacts law. The judicial branch should only interpret it." (From *Trends in Life Insurance Law*, Daniel J. Reidy, Insurance Lecture Series, University of Connecticut, Spring, 1953.)
7. Suppose the above quotation read: "I submit that it is the function of the insurance commissioner to execute the law as it is, uninfluenced by his own idea of what it should be, or by his desires to render his own ideas of alleged justice. It is not for the commissioner to rewrite the law or subvert its meaning. The legislative branch enacts law. The executive branch should only administer it." Would you agree or disagree with the statement?
8. Why do you suppose that state qualifying examinations for prospective life insurance agents are not made more difficult?
9. Are life insurance companies fairly taxed by the federal and state governments?
10. If you were elected to the state legislature, would you recommend any changes in the regulation of insurance companies?

APPENDIX

A SPECIMEN AGENT'S CONTRACT

The Stock Mutual Life Insurance Company

THIS AGREEMENT, made the _____ day of _____, 19____, to take effect the _____ day of _____, 19____, between the Stock Mutual Life Insurance Company, hereinafter called the "Company," and _____ of _____, hereinafter called the "Agent," WITNESSETH: That the Company, in consideration of the agreements of the Agent hereinafter contained, hereby agrees that the Agent may solicit and procure applications for life insurance and annuities in said Company within the territory of the _____ Agency (No. _____) of said Company; and that the Company will allow the Agent, in accordance with the following schedule and subject to the provisions of this Agreement, first year's commissions, renewal commissions and fees upon payment of premiums on policies issued upon applications procured under this Agreement.

Form of Policy and Premium Period	Commissions on				Fees on	
	1st Year Premiums	1st and 2nd Renewal Premiums	3rd, 4th and 5th Renewal Premiums	Vested as provided later	1st and Subsequent Renewal Premiums	Non- vested
	Vested in any event	Vested in any event	Vested as provided later			
Ordinary Life						
Age at Issue:						
Under 56	50%	10%	5%			2%
56	49%					
60	45%					
65	40%					
70	35%					

For ages at issue between 56 and 70 the first year commission rate is decreased by one percentage point for each increase of one year in the age at issue.

*No commission allowed on amount paid at terminal date to cover cost of conversion.

Form of Policy and Premium Period	Commissions on				Fees on	
	1st Year Premiums	1st and 2nd Renewal Premiums	3rd, 4th and 5th Renewal Premiums	Vested as provided later	1st and Subsequent Renewal Premiums	Non- vested
	Vested in any event	Vested in any event	Vested as provided later			
Limited Premium Life and Life Paid-up at 85						
30 Payments	50%	10%	5%			2%
or over	49%					
29 Payments	35%					
15 "						
For durations of premium payments between 29 and 15 the first year commission rate is decreased by one percentage point for each decrease of one year in the duration.						
14 Payments	33%					
13 "	31%					
12 "	29%	10%	5%			2%
11 "	27%					
10 "	25%					

**Modified Life Terminating at Age 70 *
(Ages 15-65)
Modified Whole Life with Reduced Paid-Up at 70
(Ages 15-55)**

Age at Issue:				
Under 51	50% 49% 45% 40%	10%	5%	2%
51				
55				
60				
For ages at issue between 51 and 60 the first year commission rate is decreased by one percentage point for each increase of one year in the age at issue.				
61	38% 36% 34% 32% 30%	10%	5%	2%
62				
63				
64				
65				

**Modified Life Terminating at Age 65 *
(Ages 15-60)
Graded Death Benefit Modified Life Terminating at Age 65 ***

Age at Issue:	10%	5%	2%
Under 51	50% 49% 48% 47% 46% 45% 43% 41% 39% 37% 35%	10%	5%
51			
52			
53			
54			
55			
56			
57			
58			
59			
60			

**Modified Life Terminating at Age 60 *
(Ages 15-55)**

Age at Issue:	10%	5%	2%
Under 51	50% 48% 46% 44% 42% 40%	10%	5%
51			
52			
53			
54			
55			

**Modified Whole Life with Reduced Paid-Up at End of 15 Years (Ages 56-70)
Modified Life Terminating in 10 Years *
(Ages 51-70)**

Age at Issue:	10%	5%	2%
51	49% 45% 44% 40% 35% 30%	10%	5%
55			
56			
60			
65			
70			

For ages at issue between 51 and 70 the first year commission rate is decreased by one percentage point for each increase of one year in the age at issue
 * No commission allowed on amount paid at terminal date to cover cost of conversion.

Form of Policy and Premium Period	Commissions on			Fees on	
	1st Year Premiums	1st and 2nd Renewal Premiums	3rd, 4th and 5th Renewal Premiums	1st and Subsequent Renewal Premiums	Non- vested
	Vested in any event	Vested in any event	Vested as provided later		vested
Graded Premium					
Ordinary Life					
With Family Income, Deferred Survivorship Annuity, or					
Decreasing Term					
Insurance Agreement	35%				
Without above		15%	15%		2%
Agreements	40%				
Annual Premium Endowment					
For the term of:					
45 yrs. or over	50%				
37-44 yrs., incl.	47%				
36 years	46%				
30 "	40%	10%	5%		2%
25 "	35%				
20 "	30%				
For durations between 36 and 20 the first year commission rate is decreased by one percentage point for each decrease of one year in the duration.					
19 years	28½%				
15 "	22½%	4%	2%		2%
10 "	15 %				
For durations between 19 and 10 the first year commission rate is decreased by one and one-half percentage points for each de- crease of one year in the duration.					
9 years	13%				
8 "	11%				
7 "	9%	2%	1%		2%
6 "	7%				
5 "	6%				

Form of Policy and Premium Period	Commissions on			Fees on	
	1st Year Premiums	1st and 2nd Renewal Premiums	3rd, 4th and 5th Renewal Premiums	1st and Subsequent Renewal Premiums	Non- vested
	Vested in any event	Vested in any event	Vested as provided later		vested
20 Premium Endowment					
Maturing in:					
40 yrs. or over	37%				
35-39 yrs., incl.	35%				
30-34 "	33%	10%	5%		2%
25-29 "	31%				
15 Premium Endowment					
Maturing in:					
40 yrs. or over	32%				
35-39 yrs., incl.	30%				
30-34 "	28%	4%	2%		2%
25-29 "	26%				
20-24 "	25%				
10 Premium Endowment					
Maturing in:					
40 yrs. or over	25%				
35-39 yrs., incl.	23%				
30-34 "	21%	4%	2%		2%
25-29 "	19%				
20-24 "	18%				
15-19 "	17%				

Form of Policy and Premium Period	Commissions on			Fees on	
	1st Year Premiums	1st and 2nd Renewal Premiums	3rd, 4th and 5th Renewal Premiums	1st and Subsequent Renewal Premiums	Non-vested
	Vested in any event	Vested in any event	Vested as provided later		

Retirement Income Endowment					
Maturity Age 55					
Age at Issue:					
5-10, incl.	37%	For ages at issue between 19-24 and 27-35 the first year commission rate is decreased by one percentage point for each increase of one year in the age at issue.			
11-18 "	34%				
19	33%				
24	28%				
25	27%				
26	27%				
27	26%				
35	18%				

36	17%	For ages at issue between 19-24 and 27-35 the first year commission rate is decreased by one percentage point for each increase of one year in the age at issue.	4%	2%	2%
37	17%				
38	16%				
39	16%				
40	15%				
41	14%				
42	13%				
43	12%	For ages at issue between 24-30 and 32-40 the first year commission rate is decreased by one percentage point for each increase of one year in the age at issue.	2%	1%	2%
44	11%				
45	10%				
46	9%				
47	8%				
48	7%				
49	6%				
50	5%				

Form of Policy and Premium Period	Commissions on			Fees on	
	1st Year Premiums	1st and 2nd Renewal Premiums	3rd, 4th and 5th Renewal Premiums	1st and Subsequent Renewal Premiums	Non-vested
	Vested in any event	Vested in any event	Vested as provided later		

Retirement Income Endowment					
Maturity Age 60					
Age at Issue:					
5-15, incl.	40%	For ages at issue between 24-30 and 32-40 the first year commission rate is decreased by one percentage point for each increase of one year in the age at issue.			
16-23 "	37%				
24	36%				
30	30%				
31	30%				
32	29%				
40	21%				

41	20½%	For ages at issue between 24-30 and 32-40 the first year commission rate is decreased by one percentage point for each increase of one year in the age at issue.	4%	2%	2%
42	20%				
43	19½%				
44	19%				
45	18%				
46	17%				
47	16%				
48	14%	For ages at issue between 24-30 and 32-40 the first year commission rate is decreased by one percentage point for each increase of one year in the age at issue.	2%	1%	2%
49	12%				
50	10%				
51	9%				
52	8%				
53	7%				
54	6%				
55	5%				

Retirement Income Endowment

Maturing in 10 Years

(Ages 46-70)

Graded Death Benefit

Retirement Income

Endowment

Maturing in 10 Years

(Ages 56-65)

Age at Issue:

46-70, incl.

Annual Premium Retirement Annuity

For the term of:

20 yrs. or over

19 "

15 "

10 "

For durations between 19 and 10 the first year commission rate is decreased by one percentage point for each decrease of one year in the duration.

9 years

8 "

7 "

6 "

5 "

4 "

3 "

2 "

2%

2%

4%

10%

2%

2%

4%

20%

2%

2%

4%

19%

2%

2%

4%

15%

2%

2%

4%

10%

9%

8%

7%

6%

5%

4%

3%

2%

Term

2 Yr. Initial Term

3 " "

4 " "

5 " "

8%

8%

8%

8%

—

—

4%

4%

2%

2%

2%

2%

If the Agent is entitled to commissions upon automatic conversion of an Initial Term policy, the commission rates after conversion shall be those shown herein for the plan to which the conversion is made.

5 Yr. Term 30% 8% 4% 2%

10 " 30% 10% 5% 2%

15 " 30% 10% 5% 2%

5 Year Renewable Term

Original Term Period 30%

8% 4% 2%

Term to Age 65

30%

10% 5% 2%

Decreasing Term Insurance Agreement — 10, 15 and 20 Year Plans — Commissions and Fees will be payable at the rates currently payable to the Agent on the policy in connection with which such agreement is issued, except that where the 10 Year Plan is issued the first year commission rate on both the policy and the agreement shall be decreased by 2% percentage points.

* This adjustment does not apply when the 10 Year Plan is attached to a G P O L policy See G P O L rates for proper adjustment

Single Payment Contracts

Life

2½%

— — —

End (10 or more

2½%

2%

2%

— — —

Annuity*

— — —

* Other than Annuity Contracts issued in pursuance of options applicable to the proceeds of life insurance policies or annuity contracts

Deferred Survivorship Annuity Agreement — Family Income Agreement — Supplementary Protective Contract — Commissions and Fees will be payable at the rates concurrently payable to the Agent on the policy in connection with which such agreement or contract is issued.

Commissions on any form of policy or contract not specified above will be allowed under this Agreement at the rates announced by the Company for such form of policy or contract

PROVISIONS

The Agent agrees to deliver policies and other vouchers, and make collections on such receipts as shall be furnished by the Company, and to account, according to the instructions of the Company, or the General Agent or other representative of the Company in charge of said agency, for all policies, premium and other receipts, vouchers, drafts, moneys and valuable papers received by the Agent from the Company or from any person for the Company's account; and further agrees that all collections made by him for the Company shall be considered as trust funds. The Agent has no authority to make, alter, vary or discharge any contract, or extend the time for payment of premiums; or to waive or extend any obligation or condition; or to take payment of premiums other than in current funds; or to incur any liability in behalf of the Company; or to deliver any policy unless the applicant therefor is at the time in good health and insurable condition; or to receive any money due or to become due the Company except on receipts sent him for collection. The Agent shall be free to exercise his own judgment as to the time, place and means of soliciting and procuring applications for insurance and annuities under the authorization contained in this Agreement.

Termination of Former Agreements

The execution of this Agreement shall terminate as of the date of the taking effect hereof any outstanding agency agreements between the parties hereto, the same as if either party had given the other notice thereof in writing, without prejudice (a) to the Agent's rights, if any, to commissions accruing under any previous agreement, or (b) to any lien or right to a lien against such commissions.

Production Standards

This Agreement will be terminated by the Company upon the failure of the Agent to meet the standards set forth below.

Definition:

"Paid-for insurance" referred to in the following standards shall be credited according to the rules governing the Company's "Paid-for Bulletin" - excluding annuities.

I The amount of paid-for insurance credited by the Company to the Agent from the effective date of this Agreement to the expiration of the first twelve full calendar months must be at least \$50,000.

II. The amount of paid-for insurance credited by the Company to the Agent in any full calendar year must be at least \$50,000, or must be at least \$25,000, if such amount when added to the amount

of paid-for insurance credited in the two preceding calendar years during the continuance of this Agreement totals at least \$150,000.

III The Agent shall conduct his business in such a manner as continuously to meet the Company's standards for classification as Full-time.

Exceptions:

The above production standards shall be waived for any year during which the Agent has been granted a leave of absence by the Company for at least six months, or during which the Agent shall have been temporarily disabled in the opinion of the Company for at least six months, and in either of such cases, the production standards set forth in II above shall be computed as though the calendar years preceding and succeeding the year in which the standards were waived were consecutive. Production standards set forth in II above shall be waived absolutely after the completion of fifteen consecutive full calendar years by the Agent under a full-time agency agreement or agreements with the Company, if the Agent has attained the age of 60 years, or in any event when the Agent shall commence to receive a pension under the Agent's Retirement Plan, or in the event that the Agent has, in the opinion of the Company, become totally and permanently disabled.

The foregoing provisions shall not prejudice the right of the

Company or the Agent to terminate this Agreement in accordance with the following paragraph.

Termination

It is hereby mutually agreed that the death of the Agent shall terminate this Agreement, and that this Agreement may be terminated at any time by either party by giving the other party notice thereof in writing.

Commissions After Termination

The Company agrees to pay to the Agent, his executor or administrator, after the termination of this Agreement, on policies issued upon applications procured under this Agreement by the Agent—

(a) First year's commissions at the rates stated above, on such of the first year's premiums as shall be paid after such termination, (b) If this Agreement is terminated by reason of the Agent's death, renewal commissions at the rates stated above, on such of the 1st to the 5th renewal premiums, inclusive, as shall be paid after such termination;

(c) If this Agreement is terminated under any other conditions, renewal commissions at the rates stated above, as follows.

(1) If such termination takes place before the completion of 5 consecutive years by the Agent under a full-time agency agreement with the Company, on such of the 1st and 2nd renewal premiums as shall be paid after such termination,

It is mutually agreed that all of the provisions stated on the following page are and shall be considered as part of this Agreement the same as though fully set forth over the signatures of the parties hereto.

This Agreement shall impose no obligation upon the Company until it is executed on its behalf by a General Agent and counter-signed by an Authorized Officer of the Company. No modification or any change in the terms hereof shall be made on behalf of the Company except in writing and signed by an Authorized Officer, but this Agreement may be terminated by any Authorized Representative of the Company.

(2) If such termination takes place after the completion of 5 consecutive years by the Agent under a full-time agency agreement with the Company, on such of the 1st to the 5th renewal premiums, inclusive, as shall be paid after such termination.

(d) If upon termination of this Agreement, the Agent shall thereafter continue immediately as a full-time salaried employee of the Company, or any of its General Agents, or under an agency agreement as a full-time field representative of the Company, then the Company will pay to him as long as he continues without interruption in any such capacity renewal commissions at the rates stated above on such of the 3rd to the 5th renewal premiums, inclusive, as shall be paid after such termination, whether or not he has qualified for such renewal commissions under the terms of sub-paragraph (c) of this provision, and in the event of his death while he is qualified for renewal commissions under this sub-paragraph, the Company will pay such renewal commissions to his executor or administrator. If he shall cease to act in any such capacity for any other reason than his death, he shall be entitled only to such further renewal commissions, if any, as he was qualified for under sub-paragraph (c) of this provision at the time of termination of this Agreement.

The Agent shall have no right to fees upon the termination of this Agreement.

IN WITNESS WHEREOF the said parties have executed this Agreement in triplicate on the day and year first above written.

THE STOCK MUTUAL LIFE INSURANCE COMPANY

By _____

General Agent

Agent

Countersigned at Urbana, Indiana, on behalf of The Stock Mutual Life Insurance Company this _____ day of _____, 19____.

Supervisor of Agents' Contracts

Entire Compensation

The Agent agrees that the commissions and fees herein provided shall constitute his entire compensation for his services hereunder; and that should the Company for any reason refund any premium on any policy covered hereunder, any commission and fee paid on such premium shall be refunded upon demand.

Advertising

The Agent agrees that he will comply with the rules and instructions of the Company now in force or issued during the continuance of this Agreement in regard to the use of all advertising matter, and any printed material which the Company may furnish.

Applications, When Procured

Any application shall be considered procured on the date of Part "2" thereof, or on the date of Part "1" when Part "2" is not required, or on the date of the written request for additional insurance where such insurance is issued on the basis of a former application.

Conversions and Other Matters Governed by Rules and Practice

The allowance of commissions and fees to the Agent in connection with the following matters shall be governed, irrespective of any other provisions of this Agreement, by such rules and practice as shall be set forth from time to time in the Company's Rules and Practice Letter and amendments thereto.

- (a) conversion into Life or Endowment policies of Convertible Term policies, Annual Premium Retirement Annuities, and other changes in plan;
- (b) premium payments on any insurance issued in exchange for or which, in the judgment of the Company, takes, or is to take, the place of insurance previously issued by the Company on the same life,
- (c) premium payments made to establish any premium due date on a date other than the Policy Date and premiums paid within one year from such new premium due date, or premiums to effect a change of any premium due date;
- (d) all other extra payments;
- (e) premiums paid by automatic premium loans;
- (f) upon each renewal of a 5 Year Renewable Term policy.

Fees and Records

The Company agrees to assume the cost of fees for licenses obtained, and medical examinations made, in accordance with the instructions and rules of the Company, to furnish such books and card systems of record or account to the Agent as the Company shall deem proper, which shall be the property of the Company,

and to furnish such necessary blanks and canvassing documents as are issued by the Company.

Changes in Commission Rates

The Company reserves the right to change the rates of commissions set forth in this Agreement by giving notice in writing of such change; but such change shall not affect any business issued upon applications procured prior to the date when such change becomes effective.

Indebtedness

Any indebtedness or liability of the Agent to the Company, whenever and however incurred, shall constitute a first lien upon and may be charged against commissions and fees due at any time under this Agreement

Any indebtedness or liability, whenever and however incurred, of the Agent to any General Agent in charge of said Agency during the continuance of this Agreement, shall constitute a lien upon and may be charged against commissions and fees due at any time under this Agreement on policies issued upon applications procured hereunder while such General Agent shall have been in charge of said Agency.

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